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TRANSACTIONS of the Canadian Dental Association



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INTERIM AND ANNUAL MEETINGS
BOARD OF GOVERNORS
APRIL 3-4 AND SEPTEMBER 11-12

1987

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PRIMAIRE ET ANNUELLE
GOUVERNEURS
LES 11-12 SEPTEMBRE

**INTERIM
MEETING
BOARD OF GOVERNORS
CANADIAN DENTAL ASSOCIATION**

OTTAWA, ONTARIO

April 3-4

1987

FORWARD

This book provides a record of the business transacted at the Interim and Annual meetings of the Board of Governors of the Canadian Dental Association, on April 3-4, 1987 and September 11-12, 1987 in Ottawa, Ontario.

All members of the Canadian Dental Association are welcome to attend and to participate in the meetings of the Boards of Governors.

During the sessions, reports of Councils, Committees and Sections, etc., are brought to open sessions of the Board, and, although the Chairman may permit any member to speak on any issue, only Board members may vote.

Interim and Annual Meeting

Words appearing in bold both within the body and at the end of the Council, Committee or Section Reports constitute the comments and actions of the Board of Governors.

The purpose of the CDA TRANSACTIONS is to provide members with a record of the policies and decisions of the Board of Governors and the work of the Association's Councils, Committees and Sections.

AVANT-PROPOS

Le présent document contient le compte-rendu des travaux des assemblées, provisoire et annuelle, du Bureau des gouverneurs de l'Association dentaire canadienne, qui ont eu lieu respectivement les 3 et 4 avril 1987 et les 11 et 12 septembre de la même année, à Ottawa (Ontario).

Tous les membres de l'Association dentaire canadienne sont bienvenus à ces assemblées auxquelles ils peuvent participer.

Les rapports des conseils, des comités et des sections ainsi que d'autres documents sont présentés au cours de séances publiques. Le président peut permettre aux membres de l'Association de s'exprimer sur diverses questions mais seuls les gouverneurs ont droit de vote.

Assemblée provisoire et annuelle

Les textes inscrits en caractères gras dans les rapports des conseils, des comités et des sections, ou à la fin, présentent les observations et les actes posés par le Bureau des gouverneurs.

Les DELIBERATIONS DE L'ADC ont pour objet de fournir aux membres un compte-rendu des orientations et des décisions prises par le Bureau des gouverneurs ainsi que des travaux des conseils, des comités et des sections de l'Association.

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T. Di Trolio, Librarian
C. Hackland, Editor

B. Henderson, Director of Education
and Accreditation
J. Neal, Director of Administration
L. Teteruck, Director of Communications
S. Vial, Accountant

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M. Boucher	Ordre des dentistes du Québec
B.L. Bowden	Newfoundland Dental Association
K. Butler	Canadian Dental Services Plans Inc.
M. Charendoff	Canadian Dental Services Plans Inc.
C. Covit	Ordre des Dentistes du Québec
H. Dick	National Dental Examining Board of Canada
J. Flynn	Newfoundland Dental Association
J. Forsythe	Canadian Fund for Dental Education
J.C. Gillies	Ontario Dental Association
T. Gushue	Newfoundland Dental Association
G.A. Howard	College of Dental Surgeons of Saskatchewan
G. Kravis	National Dental Examining Board of Canada
P.Y. Lamarche	Ordre des dentistes du Québec
W. Maillet	Nova Scotia Dental Association
B.P. Martinello	Alberta Dental Association
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R. Moran	Canadian Dental Services Plans Inc.
G. Nikiforuk	Royal College of Dental Surgeons of Ontario
D.V. Pamenter	Nova Scotia Dental Association
K.F. Pownall	Royal College of Dental Surgeons of Ontario
J. Richer	Ordre des dentistes du Québec
B. Rocky	College of Dental Surgeons of British Columbia
K.R. Skinner	Manitoba Dental Association
J.G. Thompson	New Brunswick Dental Society
R. Yamaska	Canadian Academy of Periodontology
C. Worobey	Canadian Dental Hygienists' Association

CANADIAN DENTAL ASSOCIATION

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G. Dubé

D.E. MacFarlane
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J. Hardie (Editorial Board)
A. Schwartz (Education & Accred.)
G.R. Thordarson (Ethics)
A. Toeman (Health Care)

J.H. Gryfe (Hosp. & Inst. Serv.)
Y. Kamachi (Information Serv.)
J.E. Durran (Insurance & Inv.)
P.R. Crawford (Nomin., Awards & Trusts/Membership)
R. Turcotte (Salaried Dentists)
B. Barr (Student Affairs)
R.N. Hicks (Taxation)

LEGEND

April 1987

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EXECUTIVE

REPORT TO THE 1987 INTERIM BOARD OF GOVERNORS MEETING

MEMBERS: Dr. John R. Robertson, Summerside, Chairman
Dr. Edward F. Allison, Calgary
Dr. John Christie, Bedford
Dr. Gilles Dubé, Lachute
Dr. Bradley W. Holmes, Kenora
Dr. Donald MacFarlane, Vancouver
Dr. Ron J. Markey, Vancouver
Dr. Jack W. Niedermayer, Regina
Dr. Kevin L. Roach, Pembroke

1. Council Meetings

Since the August 1986 Annual Meeting of the Board of Governors, the Executive Council has met three times - August 25, 1986, November 1-2, 1986 and February 13-14, 1987. The Executive Planning Session was held October 31, 1986.

ITEMS REQUIRING BOARD ACTION

2. FDI Delegates and Alternate Delegates

RESOLVED:

87.1 THAT the CDA official delegates to the 1987 FDI Congress in Buenos Aires, Argentina, be Dr. Robert N. Hicks, FDI National Treasurer, Dr. Ron Markey, CDA President-Elect, and Dr. George Beagrie.

THAT the CDA alternate delegates to the 1987 FDI Congress in Buenos Aires be Dr. James N. Wright, Brig. Gen. J. Fred Begin and Dr. Ralph Barolet.

ADOPTED

NOTE:

The nomination of Dr. George Beagrie as a delegate to FDI 1987 is at no cost to CDA.

EXECUTIVE

NOTE: Based on current FDI statistics, Canada is entitled to send three delegates and three alternate delegates to the 1987 FDI Congress. Names will be put forward at the Board Meeting for these two additional positions, based on the decisions taken in the recommendation contained in the FDI Subscription Report. The third delegate will not be financially supported by CDA.

3. Appointment of Auditors - Canadian Dentists' Insurance Program (CDIP)

RESOLVED:

87.2 THAT the firm of Clarke, Henning and Co. be appointed auditors for CDIP for 1987.

ADOPTED

4. Canadian Dentists' Insurance Program 1986 Financial Statements

APPENDIX A

RESOLVED:

87.3 THAT the audited financial statements for the Canadian Dentists' Insurance Program for the year ending December 31, 1986 be approved.

ADOPTED

5. Term of Office CDA President and Elected Officers

APPENDIX B

In the past, there have been occasions where the timing of the Annual Meeting of the CDA Board of Governors in conjunction with the CDA Convention has impacted negatively on the term of office of the CDA President.

Article IX - Executive Council - Section 5 states:

Members of the Executive Council shall be elected during the annual meeting of the Board of Governors pursuant to Article X.

Article X - Election of Officers - Section 8 states:

Except as otherwise provided in these By-laws, the elected officers, the members of the Executive and other councils shall assume and continue to hold office from the termination of the one annual meeting to the termination of the next following annual meeting.

EXECUTIVE

In keeping with the above section of the By-laws, the CDA President's term terminates at the Annual Board Meeting.

Future planning for CDA Conventions indicates August Meeting dates for the Annual Board Meetings in 1988 and 1989, with a resulting impact on the President's term.

Executive Council considers it advantageous to set a one-year term for the President. For example, regardless of the date of the Annual Meeting of the CDA Board of Governors, a President's term would run from October 1, for twelve calendar months, to September 30 of the following year.

Comment was requested from the Council on Constitution and By-laws, and its recommendation is appended.

RESOLVED:

87.4 **THAT regardless of the date of the Annual Meeting of the CDA Board of Governors at which elections of officers take place, the term of office for the President be from October 1 to September 30 of the following year.**

THAT all elected officers, including members of Executive Council, assume and continue to hold office from October 1 to September 30 of the following year;

THAT this term of office be extended to all members of CDA Councils and Committees; and,

THAT the above motions be referred to the Council on Constitution and By-laws for the necessary By-law amendments.

ADOPTED

6. Vacancies on Executive Council

Executive Council has requested the advice of the Council on Constitution and By-laws, on an amendment to the By-laws placing a limit on the time period that an Executive Council vacancy may remain unfilled. Response from Council is appended.

EXECUTIVE

RESOLVED:

87.5 THAT in the event of a vacancy on Executive Council, the President shall, within 90 days, appoint a member of the Board to fill the unexpired term resulting from the vacancy.

THAT the above motion be referred to the Council on Constitution and By-laws for necessary By-law amendment.

ADOPTED

7. Government Relations Committee

Executive Council reviewed the present structure and activities of the Government Relations Committee. In the past the Committee, which consisted mainly of Management Committee members, concentrated on improved relationships with the Federal Government. The formation of a standing committee to establish consistency in membership is indicated.

Composition of the Government Relations Committee is under review, and should consist of two to three members, chaired by an individual who would act as a key person in the area of Government Relations.

RESOLVED:

87.6 THAT the Government Relations Committee be a standing committee of the Executive Council.

ADOPTED

8. Ordre des Dentistes du Québec

The Executive Council considered an ongoing request that the Ordre des Dentistes du Québec receive copies of all CDA accreditation reports related to Quebec institutions.

RESOLVED:

87.7 THAT the Council on Education and Accreditation submit a motion for approval along the following lines:

EXECUTIVE

THAT a contractual agreement be established between the CDA Council on Education and Accreditation and the Order of Dentists of Quebec, under which the CDA Council on Education and Accreditation would be recognized as an agency concurrently conducting accreditation surveys in Quebec, as a provincial quality assurance process operating on behalf of the Order of Dentists;

AND THAT under the terms of the contractual agreement,

- (a) copies of accreditation survey reports on dental programs in Quebec would be officially sent to the Order of Dentists for information,
- (b) programs applying for accreditation would be asked to apply on the understanding that the accreditation process is a national process also recognized as a process operating on behalf of the Order of Dentists of Quebec,
- (c) that the accreditation process would continue to be supported financially, on terms to be negotiated periodically, by both the CDA and the Order of Dentists.

WITHDRAWN

ITEMS FOR INFORMATION

9. Medical Services Branch - Independent Review of Dental Services

The CDA has received a copy of the report of the Dental Services Review Team from Medical Services Branch, Health and Welfare Canada. The report is being analysed by Medical Services Branch, and its external distribution is, therefore, still restricted to the CDA's Executive Council. In preliminary discussion with Mr. David Nicholson, ADM - Medical Services Branch, CDA's Management Committee agreed that a joint CDA/MSB working group be formed, to explore the recommendations of the Review Team's report, and other issues and concerns related to the delivery of dental services to MSB clientele.

EXECUTIVE

Medical Services Branch members on the working group are Mr. D. Nicholson, Mr. D.A. Obonsawin, Mr. J. Hucker and Dr. W.R. Bedford. CDA members are Dr. Bradley Holmes, Dr. Roy Thordarson and Mr. Jardine Neilson. Correspondence outlining discussion at the initial meeting of November 27, 1986, is appended to the Government Relation's report. A second meeting is scheduled for March 25, 1987.

10. Management of the Life Plan Surplus

At the November Meeting, Executive Council considered a proposal put forth by the Council on Insurance and Investment, concerning the disposition of the Life Plan Surplus. The proposal covered the use of the surplus funds of the CDIP Life Insurance Plan to support and subsidize the rate stabilization reserve of the CDIP LTD Plan.

The Council on Insurance and Investment was directed to amend the proposal to reflect the concerns of Executive Council on the equity and legality of the distribution.

There were two concerns related to the distribution being considered as "legally correct":

1. That there be an equitable distribution to the participants; and,
2. that there be an on-going mechanism for dealing with future surplus funds.

Implementation of surplus distribution proposals would be effected through amendment to the 1987 Participation Agreements.

A meeting of the actuaries of CDSPI and QDSA took place on February 6, 1987 in order to provide QDSA actuaries with background information and philosophy concerning the current structure of the CDIP Life Program, surpluses and reserves.

Following this meeting, QDSA actuaries developed a number of options, indicating their opinion as to whether they comply with the CDA Executive Council direction. This material has been forwarded to the Council on Insurance and Investment for information.

Executive Council has reiterated its previous direction to the Council on Insurance and Investment, as stated above. Further, Executive Council stressed the value of a written opinion of an independent insurance consultant, on the proposal to retain a major portion of the surplus in reserve for benefit plan stabilization purposes, and its impact on the rate structure.

A deadline of June 11, 1987 has been set for response.

EXECUTIVE

11. National Strategies for Health Promotion

CDA has been requested by the Minister of National Health & Welfare, the Honourable Jake Epp, to provide comment on general directions in health promotion, as outlined in a recent address by the Minister entitled "National Strategies for Health Promotion".

Additional information is provided in the Government Relations Report.

12. Membership/Member Services

At the November, 1986 Planning Session, Executive Council approved the establishment of an Ad Hoc Committee on Membership/Member Services.

Several areas of concern indicated the necessity for a thorough review in this area. The Ad Hoc Committee was directed to review the future direction of Membership/Member Services, and the role and structure of the Membership Committee. The Report on the Ad Hoc Committee on Membership presents recommendations in this regard.

13. Review Structure - CDA Board of Governors - CDA Councils/Committees

In light of action and discussion at the 1986 Annual Meeting of the CDA Board of Governors, concerning the ACFD request for a seat on the CDA Board of Governors, Executive Council directed a review of Board structure.

Executive Council also directed a thorough review of the existing structure of CDA Councils and Committees. Amalgamation of Councils/Committees, as well as the requirement for regional representation, were among the areas to be reviewed. Geriatric dentistry and its positioning within the CDA structure was to be considered. The present role of the Council on Student Affairs was to be examined, with the goal of increasing the involvement of this Council in the current priority programs of the Association.

The Roles and Responsibilities Committee Report contains recommendations in this regard.

14. Fluoridation

The CDA is concerned that its statements and policies on fluoridation may not be consistent with current epidemiological evidence.

EXECUTIVE

Executive Council has directed the Council on Health Care to reactivate its Sub-Committee on Fluoridation, with a mandate to review CDA policies on fluoridation, and identify and recommend a CDA spokesperson on this subject.

15. CDA Seat on the CCHA Board of Directors

APPENDIX C

At the 1985 Annual Meeting, the Board adopted a policy on CDA negotiations with the Canadian Council on Hospital Accreditation, concerning an agreement to include the accreditation of hospital/institutional dental services within the CCHA accreditation process. The CDA's formal request for a seat on the CCHA Board of Directors was submitted February 16, 1987.

16. CDA Awards

Executive Council named Dr. James N. Wright as the first recipient of the CDA Award of Merit.

Certificates of Merit have been awarded as follows:

Dr. John Silver
Dr. Robert A. Turcotte
Dr. Robert R. Schiewe
Dr. Roy Thordarson
Dr. Ian Vogan

The following received letters of appreciation from the President:

Dr. Sam Sgro
Dr. Norman J. Layton
Ms. Liliane LeSaux
Dr. Sheldon Newman
Dr. James D.R. Grier
Dr. R. Kenneth Ryan
Dr. Douglas Chaytor
Dr. Gene D. Solmundson

17. ACFD Task Force on the Future of Dental Education

In November, 1986 CDA received a request from ACFD concerning plans to convene a Task Force on the future of Dental Education. The request was twofold, appointment of a CDA member to the Task Force, and financial support.

EXECUTIVE

Dr. Bradley Holmes was named as CDA's representative. In early January, the Professional Resource Utilization Committee met with the deans of Canadian Dental Faculties, and the Presidents of the ACFD and CDHA to discuss manpower issues. Additional information on the meeting is provided in the PRUC Report. As a result of this meeting, the CDA has been informed that the ACFD Task Force has been placed on hold. Reference should be made to the ACFD Report for detailed information.

18. CDIP/CDA RSP Renewals/Increases

APPENDIX D

The Council on Insurance and Investment presented motions to the August, 1986 meeting of Executive Council related to renewals and increases in CDIP, and the CDA RSP. Effective date of these renewals and increases necessitated approval prior to the 1987 Interim Meeting of the Board of Governors. Motions adopted by Executive Council are appended.

19. Organizations - CDIP Eligibility

At the 1986 Annual Meeting of the CDA Board of Governors, the Council on Insurance and Investment was directed to supply a list of organizations in relation to CDIP Eligibility.

The Council on Insurance and Investment felt it inappropriate to attach the names of organizations, and presented the amended motion below which was approved by the Executive Council.

THAT the CDA amend its eligibility requirements for participation in CDIP to include Dental Assistants and Dental Hygienists who are employed by an eligible dentist and working a minimum of 20 hours a week at the time of application.

20. CDSPI Board of Directors - New Structure

The new structure of the Board of Directors of CDSPI was reviewed by Executive Council. Importance of communication between the corporate members and their representatives to the CDSPI Board was stressed.

The CDA will ensure that its two representatives to the CDSPI Board are briefed on CDA positions on issues, prior to meetings of the Board.

EXECUTIVE

21. Capitation Awareness

Dr. Bernard Dolansky, President of the Ontario Dental Association attended the February Pre-Board Meeting of Executive Council, providing information on the ODA Awareness campaign on Capitation. Dr. Dolansky stressed the thrust of the campaign, No dentists - No Capitation, and reported on the moral and financial commitment of ODA members.

Information on the National Strategy on a Public Information Campaign on dental practice in general and alternate delivery systems, is contained in the report of the Third Party Dental Plans Committee. A meeting will be held in Toronto on March 3, to solidify financial support of CDA corporate members. Dr. MacFarlane will provide Governors with an update at the Board meeting.

22. Third World Dentistry

The CDA has received a joint proposal from the FDI and WHO, concerning the assignment of a funded Canadian dentist to the WHO Secretariat. The 1986 Planning Session endorsed CDA commitment to third world dentistry within the context of the current budgetary constraints, which cannot support financial support of this magnitude to the WHO Secretariat.

The Association continues to actively assist in the area of third world dentistry, sponsoring projects in St. Kitts and Haiti, which are supported by grants from CIDA. An application for funding has recently been submitted to CIDA for a project in Thailand - "An Alternative Model for Oral Health Care in Thailand".

23. CDA Appointments

Since the 1986 Annual Board of Governors Meeting, the President, Dr. Robertson, has made the following appointments:

- Dr. Gilles Dubé has been named Executive Liaison to the Council on Insurance and Investment, and thereby becomes a CDA representative to the CDSPI Board of Directors for the calendar year 1987.
- Dr. James Wright has been appointed as the second CDA representative to the CDSPI Board of Directors for 1987.
- The Professional Resource Utilization Committee continues under the chairmanship of Dr. Bradley Holmes.

EXECUTIVE

- Dr. John Christie has been appointed Chairman of the Roles and Responsibilities Committee. Dr. Kevin Roach has been named as a member to this Committee.
- Dr. Robert Turcotte of New Brunswick is the newly-appointed Chairman of Salaried Dentists Committee. Col. Morley Deyette has been named as the federal government representative to this Committee.
- Dr. Ralph Crawford has been named Acting Chairman of the Membership Committee, and Acting Chairman of the Council on Nominations, Awards and Trusts.
- Mr. Robert Barr is the new Chairman of the Council on Student Affairs.
- Dr. Ralph Crawford and Dr. R.V. Glover are new appointments to the Editorial Board.
- Dr. Roy Thordarson has been appointed Interim Chairman of the Council on Ethics.

24. Life and Supporting Membership Applications

APPENDIX E

Applications for Life and Supporting membership, as appended, were reviewed and approved by Executive Council.

DIRECTION: The Membership Committee will be directed to submit the list of Supporting Membership Applications to Corporate Bodies for comment, prior to submission to Executive Council for approval.

This procedure is already in place for Life Member Applications.

25. President's Activities

APPENDIX F

A schedule of activities of the President is appended for information.

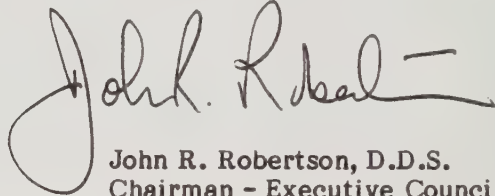
EXECUTIVE

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26. Committee/Council reports

Executive Council has reviewed Executive Committee and Council Reports as appended, and other matters requiring Board action follow therein.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "John R. Robertson", with a horizontal line at the end.

John R. Robertson, D.D.S.
Chairman - Executive Council

ADOPTION OF REPORT

The Board of Governors accepts the report of the Executive Council with appreciation.

Clarke
Henning
& Co.

Chartered Accountants

APPENDIX A

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February 2, 1987

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D. R. Hunter, C.A.
A. C. Jennison, C.A.
G. R. MacGregor, C.A.
L. F. McKay, C.A.
R. M. Post, C.A.
V. M. Raja, C.A.
D. J. Reid, C.A.
C. J. Thompson, B.Com., C.A.
M. I. Zwerg, C.A.

Attention: Mr. A. Jardine Neilson, Executive Director

Dear Mr. Neilson:

CANADIAN DENTISTS' INSURANCE PROGRAM
1986 FINANCIAL STATEMENTS

We are pleased to enclose two copies of the 1986 financial statements for Canadian Dentists' Insurance Program.

As discussed with Sandra by telephone, we recommend and have implemented a change in the format of the financial statements for 1986. In the 1986 statements a balance sheet (not presented in prior years) records not only the cash balances on hand at the end of the year, but also the amounts receivable and, on the other side, the deferred liability and accounts payable--all as of the close of business on December 31.

The statement of operations (also new for 1986) shows the gross insurance premiums for the different classes of insurance, the amounts paid or payable to the insurers, and the 15% fee payable to CDSPI.

The statement of changes in financial position records the information that was set out in the statement of receipts and disbursements in prior years.

We believe that the new format provides more information and is more readily understandable when compared with the old. If appropriate we would be pleased to attend the CDA Board meeting to discuss the new format.

If you have any questions with respect this matter please give us a call.

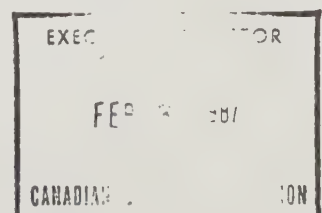
Yours very truly,
CLARKE HENNING & CO.

/jjb

V.M. Raja
V.M. Raja, Partner

Encl.

Member:
International
Affiliation of
Independent
Accounting Firms



CANADIAN DENTISTS' INSURANCE PROGRAM

FINANCIAL STATEMENTS

Year Ended December 31, 1986

Auditors' Report	Page 1
Balance Sheet	2
Statement of Operations	3
Statement of Changes in Financial Position	4
Notes to Financial Statements	5

Clarke
Henning
& Co.

Chartered Accountants

44 Victoria Street
Toronto, Ontario
Canada M5C 1Y3
Tel: (416) 364-4421



AUDITORS' REPORT

TO THE BOARD OF GOVERNORS OF
CANADIAN DENTAL ASSOCIATION

We have examined the balance sheet of Canadian Dentists' Insurance Program for the year ended December 31, 1986 and the statements of operations and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the program as at December 31, 1986 and the results of its operations and the changes in its financial position for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Clarke Henning & Co.
CHARTERED ACCOUNTANTS

Toronto, Ontario
January 29, 1987

CANADIAN DENTISTS' INSURANCE PROGRAM

BALANCE SHEET

As at December 31, 1986

	1986	1985
ASSETS		
Cash in bank	\$4,485,628	\$2,857,152
Sundry amounts receivable	56,165	73,510
	<u>4,541,793</u>	<u>2,930,662</u>
LIABILITIES		
Deferred income (premiums received from members in advance of due date)	4,453,210	1,369,463
Insurance premiums payable	-	1,533,586
Accounts payable	88,583	27,613
	<u>\$4,541,793</u>	<u>\$2,930,662</u>

CANADIAN DENTISTS' INSURANCE PROGRAM

STATEMENT OF OPERATIONS

Year ended December 31, 1986

	1986	1985
Insurance premiums - gross		
Basic life	\$2,504,596	\$2,771,131
Dependents' life	190,452	173,606
Accidental death and dismemberment	444,293	381,259
Dependents' accidental death and dismemberment	9,234	-
Long-term disability	4,686,554	4,341,339
Office overhead	1,944,566	1,806,854
Office contents	1,357,638	1,304,339
Practice interruption	463,669	427,277
General liability	458,909	433,810
Malpractice	3,146,659	1,933,670
Dentists' staff plan	8,394	-
	<u>15,214,964</u>	<u>13,573,285</u>
Insurance premiums payable to insurers	13,230,403	11,802,856
Balance, representing collection and administration fee to Canadian Dental Service Plans Inc.	<u>\$ 1,984,561</u>	<u>\$ 1,770,429</u>

CANADIAN DENTISTS' INSURANCE PROGRAM
STATEMENT OF CHANGES IN FINANCIAL POSITION

Year ended December 31, 1986

	1986	1985
Cash provided by (used in) operating activities		
Insurance premiums received, net of refunds and provincial taxes	\$18,377,026	\$13,185,653
Net premiums paid to insurers	(14,763,989)	(11,714,584)
Payments to Canadian Dental Service Plans Inc. on account of collection and administration fee	(1,984,561)	(1,986,432)
Increase (decrease) in cash during the year	<u>1,628,476</u>	<u>(715,363)</u>
Cash in bank - beginning of year	2,857,152	3,372,515
- end of year	<u>\$ 4,485,628</u>	<u>\$ 2,857,152</u>

CANADIAN DENTISTS' INSURANCE PROGRAM

NOTES TO FINANCIAL STATEMENTS

Year ended December 31, 1986

1. General

Canadian Dentists' Insurance Program offers group life, disability and other insurance to members of the Canadian dental profession, their families and employees. The program is unincorporated and operates under the authority of a participation agreement between Canadian Dental Association and the dental associations of the individual Canadian provinces.

Canadian Dental Association has entered into an agreement with Canadian Dental Service Plans Inc. whereby the latter provides collection and administration services to Canadian Dentists' Insurance Program for a fee which is calculated as 15% of the premiums paid to insurers under the program.

These financial statements present the financial position and results of operations of Canadian Dentists' Insurance Program. They do not include any assets, liabilities, income or expense of Canadian Dental Association, Canadian Dental Service Plans Inc. or any provincial dental association.

2. Comparative figures

The format of the financial statements has been changed for 1986 and the comparative figures for 1985 have been adjusted to conform with this change.

COMMENTS

COUNCIL ON CONSTITUTION AND BY-LAWS

a) Consideration as to setting of a one year term for the President

The Council on Constitution and By-Laws supports this concept. The mechanism to undertake the change would be in the form of an amendment to the current by-laws. Essentially, an amendment to either Article X, Section 8, or Article XI, Section 2, could provide a means to include a specific time period for the President's term of office.

The Council on Constitution and By-Laws suggests that October 1st would be an appropriate date, as in reviewing past annual meeting dates, the majority of these meetings have taken place by this date, and thus the provision of Article IX would not be encroached.

At the same time, the Council recommends consideration as to the practicality of not only setting the fixed one year term for the President, but extending this further to the terms for all the elected officers, the members of the Executive and other councils. If for example the President serves from October 1 of one year to September 30th of the succeeding year, it may be harmonious for the other elected officers, the Executive Council members and other councils to serve the same time period.

This change could be undertaken by amending Article X, Section 8, to reflect the time frame so selected.

b) Should a time limit be placed under Article IX, Section 6, for which an Executive Council vacancy remain unfilled

Under the current Constitution and By-Laws, Article IX, Section 6, should a vacancy exist in the membership of the Executive Council, the Executive Council shall nominate, and the President shall appoint a member of the Board to fill that portion of the unexpired term.

As a result, the power and requirement to fill a vacancy in the membership of the Executive Council currently exists.

If one wished to modify this section to provide a time frame within which the vacancy is filled, an amendment to Article IX, Section 6, wherein it would read "the Executive Council shall nominate and the President shall, within 90 days, appoint a term."

It is noted however that the appointment must come from the existing members of the Board of Governors. If the situation arises that there are also no Board of Governors from the same Corporate Body, the vacancy on Executive Council would be required to be filled by an individual who is not a representative of that area.

While the Council on Constitution and By-Laws would hope that such an occurrence would not happen in the future, the provision of a 60 or 90 day clause within Article IX, Section 6, may encourage Corporate Bodies to act within a proper time frame, in the filling of vacancies on Executive Council.

It is the opinion of the Council, however, that before any amendment is introduced relative to vacancies on Executive Council, that indepth look also be given to vacancies which could exist on the Board of Governors.

As we know it now, the Board of Governors essentially is the foundation from which the Executive Council is selected, and just as vacancies on Executive Council could lead to a lack of representation and absence of a voice from any area of our country, the absence of members from that same area on the Board level is equally a detriment to the betterment of our profession.

February 2, 1987



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

February 18, 1987

Dr. Bernard J. Pery,
Chairman,
Board of Directors,
The Canadian Council on Hospital Accreditation,
1815 Alta Vista Drive,
Ottawa, Ontario.
K1G 3Y6

Dear Dr. Pery:

As you may be aware, The Canadian Dental Association is currently conducting an accreditation process which assesses Dental Services provided in hospitals and other institutions against national standards developed and administered by the CDA Council on Hospital and Institutional Services. CDA is aware of the overall accrediting responsibility carried by The Canadian Council on Hospital Accreditation. The CDA Board of Governors has been interested in finding a way to co-operate with CCHA and assist CCHA to understand our particular concerns in the accreditation of dental services and to reflect them in CCHA's own standards and processes.

Quite frankly, although we recognize that achievement of such an integrated process is a logical step consistent with CCHA's mandate, there has been some hesitation to make a formal commitment because of a concern that the developing field of hospital dentistry still needs some of the specific and detailed assistance our accreditation process provides. Informal discussion involving Dr. Fulvio Limongelli, Mr. Brian Henderson, CDA Director of Accreditation and Dr. Jack Gryfe, Chairman of the CDA Council on Hospital and Institutional Services, helped provide reassurance that it is indeed possible to develop appropriate CCHA standards and processes and that CDA could find a continuing complementary role which would permit it to be an expert resource to developing dental services in hospitals and other health care institutions.

...2

A second concern, however, relates to the ongoing administration of the CCHA standards and processes and the desire of the Dental Profession to have a formal voice in this regard. It is felt that it is necessary for CDA to have a seat on the CCHA Board of Directors if this is to be achieved. I am sure that you will understand that it is a large step to suspend an accreditation process entirely administered by the dental profession; it would not be possible to accomplish this without the formal participation of the dental profession on the Board which absorbs this responsibility. The Board of Governors of the Canadian Dental Association has formally empowered CDA administration to negotiate with CCHA and attempt to integrate the goals of our accreditation process within CCHA's standards and procedures. The Board has provided the attached resolution for guidance in such negotiation.

The purpose of this letter is to present, in a formal fashion, CDA's request for a seat on the CCHA Board of Directors, together with the background information. We have delayed submitting this request as it is understood that the CCHA Board of Directors will be discussing, in the near future, the general question of the structure and composition of the CCHA Board. Members of the CCHA Board may wish to consider the merits of our request for CDA representation during the course of such discussion. I sincerely hope that the members of the CCHA Board of Directors will look upon this request for representation favourably and subsequently encourage our respective administrations to conclude all necessary arrangements for CCHA to assume its further responsibilities in accreditation of hospital dental services with the assistance and support of the dental profession.

Yours sincerely,

A handwritten signature in dark ink, appearing to read "John R. Robertson". The signature is fluid and cursive, with a long horizontal stroke at the end.

John R. Robertson,
President.

RESOLUTION COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES
1985 ANNUAL MEETING, CDA BOARD OF GOVERNORS

85.98 Canadian Council on Hospital Accreditation

THAT the Canadian Dental Association negotiate an agreement with the Canadian Council on Hospital Accreditation to include the accreditation of hospital/institutional dental services within the CCHA accreditation process, on the following terms:

- (1) The Canadian Dental Association shall have at least one permanent voting representative on the CCHA Board of Directors.
- (2) The Canadian Dental Association shall have satisfactory input into definition of sections of CCHA accreditation requirements related to hospital dentistry and into the education or orientation of accreditation surveyors.
- (3) CCHA will agree to require hospital dental services being accredited for the first time to be reviewed by a survey team, appointed and directed by the CDA Council on Hospital and Institutional Services.
- (4) Appropriately qualified dentists will be considered eligible for service on CCHA accreditation survey teams on the same basis as physicians, registered nurses and hospital administrators.

ADOPTED



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

January 6, 1987.

Dr. Athol L. Roberts,
2 Crestwood Drive,
Charlottetown, P.E.I.,
C1A 3H3

Dear Dr. Roberts:

Thank you sincerely for your letter of December 9th, and the news that you propose to support CDA's application for a seat on the Board of the Canadian Council on Hospital Accreditation. I know that members of staff at our respective associations have been discussing this issue, and have been much encouraged by the positive reception that our representatives have received.

I thought you might be interested in some background as to why a formal application from CDA did not get placed on the agenda of the December meeting. Basically, we were advised that the whole question of the structure of the CCHA would be coming up for review, and that it was unlikely that representatives from the hospital administration sector would support any changes in board membership prior to this review (as there were concerns about the balance between providers and administrators). We were also advised that with the departure of Dr. Limongelli, and the need to appoint a successor, such a review would probably not occur before Summer 1987 at the earliest.

Accordingly, we shall shortly be writing to CCHA requesting that consideration be given to a CDA seat on the CCHA Board of Directors when the review is undertaken. Needless to say, your support will be invaluable and appreciated.

I believe that our professions have many common interests and problems, and would welcome any opportunities for mutually supportive initiatives.

Kindest regards,

Yours sincerely,

John R. Robertson,
President.

adh

c.c. B. Henderson

Athol L. Roberts M.D. C.M.

2 CRESTWOOD DRIVE, CHARLOTTETOWN, P.E.I. C1A 3H3

December 9, 1986

Dr. John R. Robertson
Canadian Dental Association
216 Linden Avenue
Summersaide, P.E.I.
C1N 4N4

Dear Dr. Robertson,

I hasten to acknowledge the very kind letter you wrote to me on October 27, 1986 bearing your congratulations on my election to become the President of the Canadian Medical Association in August 1987.

It was very kind of you to take time from your busy schedule to think of me. By now you are well aware of the tremendous strain and work involved in your own appointment. I sincerely hope that I will have continued good health to perform my duties as well as expected by good people like yourself.

By way of interest, I am happy to support the application of the Canadian Dental Association for a seat on the Board of the Canadian Council on Hospital Accreditation. This matter will be discussed at a Board meeting on December 12, 1986.

Warm regards.

Yours sincerely,



Athol L. Roberts, M.D.

/rvr

APPENDIX D

CDIP/CDA RSP RENEWALS/INCREASES

MOTIONS: R Markey/J. Christie

THAT effective January 1, 1987, an automatic increase of 8% on office contents and practice interruption coverage be implemented.

CARRIED

THAT the CDA RSP contract be renewed with Imperial Life for the period January 1, 1987, to December 31, 1989, at the rates outlined in the August 14, 1986 letter of Imperial Life.

CARRIED

Changes to Benefit Plans - Effective January 1, 1987

Basic Life

THAT the waiver of premium provision be expanded to provide for a refund of premiums back to commencement date of disability after the first six months of disability have been completed.

CARRIED

Dependents' Life

THAT the waiver of premium provision be expanded to provide for a refund of premiums back to commencement date of disability after the first six months of disability have been completed.

CARRIED

Accidental Death and Dismemberment

THAT a waiver of premium provision be included to provide for a refund of premiums back to commencement of disability after the first six months of disability have been completed.

CARRIED

Long Term Disability

THAT the monthly maximum of benefits be increased from \$5,000 to \$6,000.

THAT a new definition of disability will be:

"Total disability means that because of injury or sickness:

1. you are unable to perform the important duties of your regular occupation; and
2. you are under the regular and personal care of a physician".

THAT the current contract be amended to show a "zero" day disability requirement before payment of residual benefits takes place.

CARRIED

Office Overhead

THAT the monthly maximum of benefits be increased from \$8,000 to \$10,000.

THAT an extended benefit feature be added to the office overhead coverage.

THAT a future insurance guarantee (FIG) provision be added to the office overhead expense benefit whose terms and conditions are the same as that currently available under the LTD.

THAT a survivor benefit be added to the master contract extending the office overhead benefit for three months following the month in which the insured's death occurs.

CARRIED

Financial Contract Renewal Matters - Effective January 1, 1987

THAT the current billed life rates be maintained.

THAT the current experience-rated portion of the subsidy for life premium be discontinued for 1987, and that the Imperial Life reduce the pooled portion of such a subsidy in 1987 by 50%.

THAT there be no change to dependents' life premium rates for 1987.

THAT the current LTD premium rates remain at current level with a subsidy of up to 10% of net 1987 premium to come from plan surplus if required.

THAT the current office overhead expense premium rates be decreased by 15% and the amount of the reduction be applied to a realignment of the current rates.

THAT the rate stabilization reserve of the LTD and office overhead be restocked from surplus as required to a maximum level of \$896,229.

THAT items in retention which are subject to inflationary adjustments should be equal to the lesser of,

- a) the annual increase in the aggregate industrial wage index, or
- b) 12%.

with such formula for basic and dependents' life to be for a 3-year period and for LTD and office overhead expense to be for a 1-year period.

THAT financial reports on the Imperial Life plans be provided at four months and eight months at \$1,000 per report in the same present format, with the annual report being provided in the current format at no charge.

THAT quarterly LTD and office overhead claims reports and regular information data input sheets be provided at no charge.

THAT the interest basis applicable to reserves for open claims be amended to a five-year term deposit basis.

THAT claims settlement expense payable to Imperial Life be equal to 2 1/2% of incurred LTD and office overhead expense claims with all other flat charge and cheque charge, other than rehabilitation costs, being deleted.

CARRIED

Renewals: January 1, 1987 - December 31, 1989

THAT the basic life, dependents' life, long term disability and office overhead expense contracts be renewed with the Imperial Life Assurance Company of Canada for the period January 1, 1987 to December 31, 1989.

THAT the accidental death and dismemberment contract be renewed with Seaboard Life Insurance Company for the period January 1, 1987 to December 31, 1989, at current premium rates.

CARRIED

CANADIAN DENTAL ASSOCIATIONAPPLICATIONS FOR LIFE MEMBER STATUS 1987

<u>NAME</u>	<u>PROVINCE</u>	<u>YEAR OF GRADUATION</u>
DR FERNAND BEAUDOIN	QUEBEC	1946
DR ROBERT H COHEN	QUEBEC	1944
DR JEAN P LACHAPELLE	QUEBEC	1946
DR JACQUES LALANDE	QUEBEC	1946
DR PAUL-S TESSIER	QUEBEC	1946
DR R E BREEN	ONTARIO	1946
DR R A CLAPPISON	ONTARIO	1946
DR D G LANGMAID	ONTARIO	1946
DR R W MARSHALL	ONTARIO	1946
DR W J MCCOLEMAN	ONTARIO	1946
DR WILLIAM C MCCOMB	ONTARIO	1946
DR W P MCMANUS	ONTARIO	1946
DR CHARLES B MORROW	ONTARIO	1946
DR WILFRED J ROVAN	ONTARIO	1946
DR T H WACHNA	ONTARIO	1946
DR M B RUDISAILE	MANITOBA	1946
DR A J SHINOFF	MANITOBA	1946
DR G A BRENNAN	B C	1946
DR JOE C RIFE	B C	1946
DR J BLAIR WOLFE	B C	1946

CANADIAN DENTAL ASSOCIATION

APPLICATIONS FOR SUPPORTING MEMBER STATUS 1987

<u>NAME</u>	<u>PROVINCE</u>	<u>REASON</u>
DR DAVID T O'CONNELL	P E I	Total Dentistry Disabled
*DR J C ANDRE DALLAIRE	N S	Strictly Millitary dentistry - low salary - does not benefit from C.D.A. services
DR JOHN STERRETT	N S	Not licensed
DR GILLES ALLAIRE	QUEBEC	Invalid since 1977
DR YVON AMYOT	QUEBEC	Not licensed
DR ROSAIRE CANTIN	QUEBEC	Retired
DR DONALD C CHALONER	QUEBEC	Retired
DR ARMAND CHAREST	QUEBEC	Retired
DR J L ANDRE DALPE	QUEBEC	Retired
DR JEAN PAUL LACHAPELLE	QUEBEC	Eligible Life Membership
DR GERARD R MERCIER	QUEBEC	Retired
DR MARIUS PARE	QUEBEC	Retired
DR ANTOINE RAYMOND	QUEBEC	Retired
DR PIERRE M SMITH	QUEBEC	Resides Canada/U.S.A.
DR ANDRE ST JEAN	QUEBEC	Retired
DR J A ALEXANDER	ONTARIO	Retired
DR R G BALDERSON	ONTARIO	Retired

DR GARY S BLACKSTEIN	ONTARIO	Not Licensed - living in Israel
DR G J BOUCHER	ONTARIO	Retired
DR ROGER BOURGEOIS	ONTARIO	Retired
DR R T BOYD	ONTARIO	Retired
DR ROBERT A BRANDON	ONTARIO	L.T.D. M.V.A.
DR R E BREEN	ONTARIO	Chronic Illness - eligible Life Member status
MS ISABEL BROWN	ONTARIO	Non-Dentist
DR G A DELAGRAN	ONTARIO	Retired
DR J R DEVINE	ONTARIO	Retired
DR ERNEST I FEDUN	ONTARIO	Mentally incompetent
DR W K HETTENHAUSEN	ONTARIO	Mitigating Circumstances
SUNITA JOSHI	ONTARIO	Non-dentist
DR ROBERT H LYNCH	ONTARIO	Extended Sabbatical
LENNART MALMBERG	ONTARIO	Non-Dentist
DR JOHN C MCCAVOUR	ONTARIO	Retired
DR GEORGE T MILNE	ONTARIO	Fully Retired
DR A ROMANO	ONTARIO	Retired
CAROL WROBEY	ONTARIO	Non-Dentist
DR GERRY WRIGHT	ONTARIO	Non-Dentist
DR IAN S ZAGDANSKI	ONTARIO	Non-Practising dentist
DR H C SWARTOUT	ALBERTA	Retired
DR M M WORONUK	ALBERTA	Retired
DR DEAN R BONLIE	B C	Not Licensed
DR DAVID R HEFT	B C	Disabled - Not Licensed
DR S B SMORDIN	B C	Retired

DR JOSEPH E MACDONALD	B C	Fully Retired
DR COSMO CASTALDI	U S A	Not Licensed Canada
DR WAYNE FROSTAD	U S A	Not Licensed Canada
DR NEWTON C GORDON	U S A	Not Licensed Canada
DR HERBERT HOPS	U S A	Not Licensed Canada
DR JAMES E MCCORMICK	U S A	Not Licensed Canada
DR H J PATRICK	U S A	Not Licensed Canada
DR ROBERT RAPP	U S A	Not Licensed Canada
DR ARTHUR RETZLAFF	U S A	Not Licensed Canada
DR LEONARD TEICHER	U S A	Not Licensed Canada
DR NATHAN TIFFENBERG	U S A	Not Licensed Canada
DR AMEETA CLOUGH	ENGLAND	Not Licensed Canada
DR ROBIN B DICKSON	ENGLAND	Not Licensed Canada
DR J B DICKINSON	BERMUDA	Not Licensed Canada
DR G G LEHMANN	AUSTRALIA	Not Licensed Canada
DR S C MARECHAUX	SWITZERLAND	Not Licensed Canada
DR R F K THAM	CHINA	Not Licensed Canada

* = Not recommended by Ad Hoc Committee, January, 1987:



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

SCHEDULE**PRESIDENT - DR. JOHN R. ROBERTSON****1986**

August 23	CDSPI Annual Meeting	Halifax
August 25	Executive Council	Halifax
Sept. 5-7	Conf. Board of Canada	St. Andrews
Sept. 12-14	Northern Ontario Convention	Timmins
Sept. 17	Prov. Dental Directors Conference (represented by Dr. Markey)	Calgary
Sept. 18	ADA/CDA Executive Meeting	Chicago
Sept. 25	NSDA Student Night	Halifax
Sept. 29	Meeting Premier PEI	Charlottetown
Oct. 6-7	Canadian Medical Colleges	Toronto
Oct. 8	Laval University	Quebec
Oct. 9	University of Montreal	Montreal
Oct. 17	ODA Special Meeting	Toronto
Oct. 18-21	American Dental Convention	Miami
Oct. 21	Toronto - All Societies Meeting (represented by Dr. Markey)	Toronto
Oct. 22	CDSPI/CDA Management	Toronto
Oct. 28	Management/Dr. Landry	Ottawa *

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Oct. 29-30	Management Committee	Mont Ste-Marie
Oct. 31-Nov.2	Executive Council	Mont Ste-Marie
Nov. 9-15	FDI Congress	Manila
Nov. 17	Welcome to the Profession McGill University (Represented by Mr. Neilson)	Montreal
Nov. 18	University of Toronto - Student Night (Represented by Mr. Neilson)	Toronto
Nov. 19	Univ. of Western Ont. - Student Night (Represented by Dr. Leggett)	London
Nov. 20	Winter Clinic (Represented by Dr. Markey)	Toronto
Nov. 21-22	ODA Board (Represented by Dr. Markey)	Toronto
Nov. 23-24	NDEB	Ottawa
Dec. 5	Licensing Bodies Conference	Toronto

1987

Jan. 14-18	Manitoba Dental Association	Winnipeg
Feb. 10	Call the President Day	Ottawa
Feb. 11-12	Management Committee	Ottawa
Feb. 13-14	Executive Council	Ottawa
March 26	Sherbrooke Society Meeting	Sherbrooke
March 27-28	Atlantic Provinces Dental Executive Committee	Halifax
April 3-4	CDA Interim Meeting - Board of Gov.	Ottawa
May 1-2	Annual General Meeting - Newfoundland Dental Association	St-John's
May 2	New Brunswick Annual Meeting	Fredericton

May 8-9	ODA Board	Toronto
May 10-12	ODA Convention	Toronto
May 24-28	CDA/ODQ Convention	Montreal
June 11-13	Saskatchewan College Convention	North Battleford
June 18-21	College of Dental Surgeons of B.C. Convention/UBC 25th Anniversary	Vancouver
June 24-25	Management Committee	Ottawa
June 26-27	Executive Council	Ottawa
June 28-July 1	Conjoint Alberta Dental/Pacific Dental Federation Convention	Banff
Aug. 6-7	CFDS Grad Ceremonies	Borden
Sept. 4-6	Northern Ontario Dental Society	North Bay
Sept. 10	Presidents and CEO's	Ottawa
Sept. 11-12	Annual Board	Ottawa

* Tentative

1987-03-05

/ml

FDI NATIONAL TREASURER

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

1986 FDI ANNUAL WORLD DENTAL CONGRESS

MANILA, PHILIPPINES

NOVEMBER 9-15, 1986

Items For Information - Not Requiring Board Action

The 74th Annual World Dental Congress was opened by a moving and historical address by President Corazon C. Aquino. The President of the Republic of the Philippines extended a warm and sincere welcome to members of the General Assembly and delegates to the congress in her one-half hour address. She displayed her knowledge of preventive dentistry and commended the profession on their worthwhile goal of achieving dental health for the world's population. The President also called upon the dentists of her country and dentists from international locations to work together to help the people of the Philippines work towards this goal in their troubled and impoverished country.

The historic portion of her address occurred when she completed the dental-oriented remarks, turning from the audience and directing her final remarks to the many television cameras in the Plenary Hall. Her final message was to the people of her country, and particularly to those people who may be interested in obtaining control of the government after her departure to Japan the following day. President Aquino delivered a strong message, including the commitment to go to war, if necessary, to protect the independence of the people which, as a country, they work so hard to obtain. I feel most delegates in the audience wished that the President had made these remarks the week after they left the congress rather than the week they were there! However, a very pleasant, peaceful week resulted with all delegates truly indebted to the Philippines' dental community for their wonderful hospitality.

The attendance at the FDI Manila meeting was less than anticipated due to the potential unrest that could develop in the country. Those who attended the congress experienced a happy population with the only signs of unrest surfacing in the media. 1209 international delegates attended with Canada ranking 4th-5th in the preliminary registration statistics.

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FDI NATIONAL TREASURER

Canada was represented at the General Assembly of the Congress by a Councillor - Dr. William R. Thompson, by two official delegates - Dr. John Robertson (CDA President) and Dr. Robert Hicks (National Treasurer - Canada) and by two alternate delegates - Brig. Gen. James Wright and Dr. George Beagrie.

Additional Canadians who participated in FDI Commissions throughout the year as consultants or participants are as follows:

Commission on Oral Health, Research and Epidemiology

- Dr. George Beagrie
- Dr. William Bedford
- Dr. Daniel Kandelman
- Dr. Malcolm Williamson

Commission on Dental Education and Practice

- Dr. George Beagrie - Chairman
- Dr. E.R. Ambrose
- Dr. D. Donaldson
- Dr. R.B. Gilliland
- Dr. G. Kravis

Commission on Dental Products

- Prof. D.S. Smith
- Dr. Frank Pulver
- Dr. Harvey Bridges
- Dr. B.A. Wright
- Dr. Ralph Barolet

Commission on Dental Forces Dental Services

- Brig.Gen. James Wright - Vice-Chairman
- Brig.Gen. William Thompson

Canada also played a very active role in participating in the extensive scientific program arranged by the Philippines Organizing Committee. Those Canadians lecturing or making presentations were as follows:

FDI NATIONAL TREASURER

Main Theme Session:

- Dr. A. Lowe
- "Undergraduate and Continuing Education in Orthodontics"

Supporting Lectures:

- Dr. Allan A. Lowe
- "Three-dimensional Analysis of Tongue Posture"

Symposiums:

Commission on Oral Health, Research and Epidemiology
"Low Technology Approach to Dental Care"

- Dr. Murray Dickson
- "Appropriate Dental Training"

Commission on Dental Education and Practice
"Improving Access to Oral Health Care"

Dr. George Beagrie - Chairman

Free Communication Sessions:

- Dr. Daniel P. Kandelman
- "Xylitol Chewing Gums in Preventive Program - Effect on Dental Caries"
- "A Collaborative WHO Clinical Field Trial in French Polynesia"

- Dr. R. Go
- "Myofunctional Appliances for the General Practitioner"

Table Demonstrations:

- Dr. G.T. Santander
- "Restoration and Re-Use of Endodontically Treated Teeth"

- Dr. L. Abelardo
- "Preventive Resin Restoration"

FDI NATIONAL TREASURER

Special Sessions:

- Meeting of the Deans
Dr. George Beagrie - Chairman
- International Cooperative Oral Health Development
Program (ICOHDP) Progress
Dr. William Bedford
- "Mozambique - Canada"

The major business activities of the FDI took place in four main working sessions, i.e. General Assembly A, General Assembly B, the National Treasurers Meeting, and the Open Question Period. While these are the official meeting opportunities for general business of the Association, informal and/or small scheduled meetings occurred during the week to provide additional discussion and "persuasion" sessions. The following is a brief summary of the main items of interest from General Assembly A and General Assembly B:

1. Annual World Dental Congress Sites

The General Assembly approved Vancouver, Canada as the 1994 site of the FDI Annual World Dental Congress. As with all other congress site selections, this invitation presented by CDA is accepted provided that satisfactory agreements can be reached with regard to the congress facilities, hotel accommodations, transportation by the airline and the dental trade exhibition.

A number of other site locations were also approved resulting in the following schedule for future congresses:

1987	-	Buenos Aires, Argentina
1988	-	Washington, D.C., USA
1989	-	Amsterdam, Netherlands
1990	-	Singapore
1991	-	Rome, Italy
1992	-	City not named, West Germany
1993	-	Gothenburg, Sweden (tentative)
1994	-	Vancouver, Canada

FDI NATIONAL TREASURER

2. Elections

I am pleased to report that Dr. William R. Thompson, Canada was re-elected to a further three year term as a Counsellor of the FDI. There were seven candidates, and Dr. Thompson received the second highest number of votes on the first ballot.

In addition, I am also pleased to report that the Commission on Dental Forces Dental Services elected Brig. Gen. James N. Wright, Canada as their Vice-Chairman, and the Commission on Oral Health, Research and Epidemiology re-elected Dr. George Beagrie, Canada as their Chairman.

3. Finances

A large part of the General Assembly meetings plus the associated National Treasurers meeting and the Question Period dealt with the troubled finances of the FDI. In past years, the Assembly has refused to increase individual membership dues and the attendance at the past two FDI Annual World Dental Congresses has been disappointing. These factors together with the fact that the value of the US dollar (the source of FDI funding) has decreased significantly in Great Britain, has resulted in a lower level of income than expected. However, current expenditures were reduced and the annual financial statements showed a modest excess of revenue over expenditures.

The Finance Committee, chaired by the Treasurer, emphasized the need to obtain substantial income from outside sources. Corporate fund-raising and increased solicitation of new members will be initiated. It was also recommended that a very conservative approach was needed when selecting the exchange rate (British Pound vs US Dollar) for the preparation of the annual budget. To provide a certain edge against currency fluctuations, the Assembly amended the Regulations to permit the following:

- Subscriptions of member association shall be payable on the basis of the value of the pound sterling on January 1st of that year.
- Subscriptions of supporting members shall be payable on the basis of the value of the US dollar on January 1st of that year.

The implementation date of these changes will be at the time considered to be most opportune by the Federation's financial advisors.

The 1987 budget showed an increase in expenditures of 11.8%. This increase was centred mainly on the headquarters office expenses due to the increased activity of the Association. The total 1987 budget expenditure is US dollars \$851,000.

Since the congress and supporting membership revenue is projected to be lower than usual once again in 1987, the Finance Committee found it necessary to shift more of the revenue requirements on to the Supporting Member Associations until increased revenue from corporate funding and increased supporting membership can be realized. This resulted in a 32.86% increase in 1987 subscriptions for each Supporting Member Association. Canada suffered further by an updating of their "formula data" which resulted in a total 81.2% increase in our 1987 Annual FDI subscription. A supplementary report is attached to this report which explains this increase in more detail.

Considerable debate resulted over the five days between the two Assembly meetings but in the final vote on the budget, all nations agreed that the budgetted expenditures were reasonable, the program activities were needed, and the large increase in Supporting Member Association subscriptions (according to the existing formula) were necessary. However, the following two changes in 1987 revenue were approved:

- The subscription of Supporting Members be increased from US dollars \$18 to \$22 from January 1, 1987.
- The subscription to the International Dental Journal be increased from US dollars \$27 to \$38 effective January 1, 1987.

Affiliate Member Association subscriptions were also increased from \$150 to \$250, and from \$250 to \$350. In addition, to discourage late payment of Member Association subscriptions, which are due January 1, 1987, the following amendment to the regulations was also made:

- Interest of 10% per annum shall be charged on subscriptions not received by March 31st.

4. Technical Reports

The following FDI Technical Reports were presented to the General Assembly and were approved:

- Topical and Systemic Anti-microbial Agents in the Treatment of Chronic Gingivitis and Periodontitis

FDI NATIONAL TREASURER

- Guidelines for Antibiotic Prophylaxis of Bacterial Endocarditis for Patients with Cardiovascular Disease
- Guide to the Use of Glass Ionomer Filling Materials

5. Information Reports

The following Information Reports were approved by the General Assembly:

- Dentistry as a Profession
- Recommendations for Hygiene in Dental Practice including Treatment for the Infectious Patient
- Guidelines for the Additional Training of Dental Officers in Connection with the Treatment of Those Injured in Disaster Situations

6. New Business

The main item of new business from the floor of the General Assembly was a motion (passed) to establish a Task Force to review the objectives and future activities of the FDI. This Task Force will report back to the General Assembly in Buenos Aires, in 1987. The five members on the Task Force are:

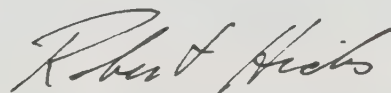
Dr. John Bomba, Chairman - USA
Dr. R. Duckworth - Great Britain
* Dr. William Thompson - Canada
Dr. Thorsten Aggeryd - Sweden
Dr. Norman Whitehouse - Great Britain

The underlining intent of this motion is to have a serious review of the objectives, activities, administration, purpose and related cost/revenue of the FDI. The creation of this Task Force reflects the overall concern of all countries in FDI that individual memberships are decreasing, attendance at "low interest" Congress sites is decreasing and increased budget requirements are creating increased financial responsibilities for supporting countries.

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While individual voices are often lost in the expansive arena of a world organization until the individual is recognized as a "player" (i.e. Dr. William Thompson - Canada), the writer of this report was pleased to see the General Assembly as a whole desired to have an indepth look at FDI to see whether it is performing what is expected of it as a true international dental organization.

Respectfully submitted,



Dr. Robert Hicks, D.D.S., M.S.
National Treasurer - Canada

ADOPTION OF REPORT

The Board of Governors accepts the report of the FDI National Treasurer with appreciation.

1987 FDI ANNUAL SUBSCRIPTION REPORT

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Items Requiring Board Action

A. CDA 1987 FDI ANNUAL SUBSCRIPTION

As a Supporting Member Association of the FDI, the Canadian Dental Association's 1987 subscription will be US \$17,034 (approximately CDN \$23,677). This represents an 81.2% increase over the 1986 subscription of US \$9,603 (approximately CDN \$13,348).

This extremely large increase results from two factors:

1) The FDI 1987 Budget:

APPENDIX A

The revenue for FDI is based on three main sources - individual Supporting Member Subscriptions, income from World Dental Congresses, and Supporting Member Association subscriptions.

The expenditures for FDI center around the association providing headquarters support for the various FDI committee projects. Travel expenses for staff to the congress is not part of the budget since it is included in the Congress budget. Over 50% of expenditures relate to maintaining a Headquarters office in London.

The 1987 FDI budget was approved, after a lengthy debate, resulting in a 11.8% increase over the 1986 budget. However, with decreasing revenue from Annual World Dental Congresses (i.e. 1985 Belgrade - US \$56,000 less than budget), decreasing individual Supporting Members subscriptions (i.e. 1985 - US \$31,000 less than budget) and a falling British Pound exchange rate (i.e. a strong US dollar adds additional dollars to support the London Headquarters expenses), it is now necessary to seek financial support from the only immediate source on a short term basis - the Supporting Member Associations.

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1987 FDI ANNUAL SUBSCRIPTION REPORT

Upon this basis, the general assembly accepted an unprecedented shift from 38% to 44.7% of the budget revenue being assigned to Supporting Member Association. This shift resulted in an increase of 32.8% in the usual funds required from the Member Associations.

Current activities are in place to obtain greater revenue from Corporate sponsors such as the "Friends of the FDI".

2) The FDI Supporting Membership Association Funding Formula:

A number of years ago, a formula was created, by the FDI, in order to allocate the portion of the revenue required from each Supporting Member Association, on an equitable basis. The two determinants in this formula are:

- a) The number of members belonging to the Supporting Member Association;
- (b) The national average annual income in the country of the Supporting Member Association (as recorded in the World Bank Atlas).

The actual formula operates in the following manner:

- $\text{Members} \times \text{per Capita Country Income} = \text{Factor A}$
- The Sum of the Factor A for all countries is calculated. Each country's Factor A is divided into this sum to create a percentage called F% (Factor C) for each country.
- This Factor C is used to calculate the amount of budget revenue assigned to each Supporting Member Association. Each country is required to pay this amount as its annual subscription.

In 1986, Canada had a Factor C (F%) of 3.288 resulting in a US \$9,403 subscription. In 1987, Canada has a 4.483 Factor C resulting in a US \$17,034 subscription (i.e. due to budget increase plus an increase in the Factor C).

If the Factor C had remained constant in 1987, Canada would be required to pay US \$12,494 (a 36.3% increase) based on the budget increase only. The increase in our Factor C represents the additional 44.9% in our overall 81.2% increase over 1986.

1987 FDI ANNUAL SUBSCRIPTION REPORT

More correctly stated, of the US \$7,631 increase in our 1987 Supporting Member Association subscription to FDI, the budget is responsible for 59.5% of the total increase while our increased Factor C is responsible for 40.5% of the total increase.

With regard to the increase in Canada's Factor C, both the number of members in the Canadian Dental Association was increased and the per capita national income was increased.

FDI stated in the "Comments on the FDI Budget for 1986-87 (Appendix I)", that, where countries did not supply their latest membership figures, 10% was added to their 1986 total. In 1986, CDA was recorded as having 8,541 members. In 1987, FDI recorded 9,099 CDA members for Canada (a 6.5% increase).

In 1986, the World Bank Atlas 1981 was used to record a Canadian per capita national income of US \$9,133. For the calculation of the 1987 Factor C, the World Bank Atlas 1986 was utilized which resulted in a Canadian per capita income of US \$13,140 being utilized.

In summary, the 1986 and 1987 Factor C for Canada was calculated in the following manner:

	<u>Members</u>	<u>PCI</u>	<u>Factor C</u>
1986	8,541	9,133	3.288
1987	9,099	13,140	4.483

It should be noted that our increase in Factor C to 4.483 permits Canada to increase from two (2) to three (3) official delegates at the General Assembly.

B. CDA'S ANNUAL FDI COSTS

In addition to the annual FDI Supporting Member Associations subscription, the CDA incurs additional costs related to sending official delegates to the Annual World Dental Congress and to promoting FDI individual Supporting Membership in Canada.

At the present time, it is CDA policy to financially support the following activities (1985 approximate costs included for information):

1987 FDI ANNUAL SUBSCRIPTION REPORT

-	Travel, accommodation, meals, FDI membership, Congress registration and associated events for two official delegates and spouses.		
i.e.	- the President of CDA		
	- the FDI National Treasurer - Canada	CDN	\$18,244.00
-	Travel, accommodation, meals, FDI membership, registration and associated Congress events not covered by FDI for Counsellor, Dr. William Thompson and spouse.	CDN	<u>\$2,036.11</u>
	SUB TOTAL		\$20,280.11
-	FDI Annual Subscription	CDN	\$12,133.34
-	FDI Membership Promotion (Mailing)		<u>\$4,632.55</u>
	TOTAL EXPENSE	CDN	\$37,046.00

From Membership Promotion in Canada:

-	Membership revenue received	CDN	\$16,669.69
-	Membership forwarded	CDN	<u>\$12,913.20</u>
	REVENUE		\$3,756.49

1985 Net FDI Costs: \$33,289.51

While the policy has been in place for a number of years (Dr. Thompson's compensation was added when he was elected as Counsellor three years ago), the costs vary from year to year depending on the location of the Congress. In 1986, FDI discontinued the practice of charging national treasurers the registration fee (approximately CDN \$300 per delegate).

The CDA gained some revenue by charging Canadian FDI members an administration charge in addition to the FDI supporting membership subscription.

1987 FDI ANNUAL SUBSCRIPTION REPORT

C. FUTURE FDI MEMBERSHIP

The large increase in the annual CDA subscription to the FDI is certainly a difficult amount "to swallow". Considerable lobbying by the Canadian delegates and Counsellor Dr. William Thompson occurred at the 1986 Manila meeting.

Dr. Thompson was able to gain support of the FDI Council (similar to our Executive Council) for our proposal that a 32.8% increase be applied to each country to cover the budget requirements. This proposal suggested that "the formula" not be applied in 1987 in order that each country would share the increased cost equally. However, this proposal was not accepted by the General Assembly after a lengthy presentation by Canada. In order for Canada's proposal to be successful, a unanimous vote of the General Assembly was required.

During the week long discussions on this difficult issue, the FDI Council agreed to look at the "formula" and bring forward recommendations that would create a more equitable method of sharing Member Association's financial responsibilities. In many countries, the per capita income factor does not truly represent the national dental association's ability to pay their share.

As I mentioned in my Manila Congress report, the finances of FDI were the center of all discussions. More revenue must be obtained from other than Member Associations. Corporate funding and increased Supporting Member Subscriptions are being sought. The location and time of World Congresses are also being reviewed. The very structure and objectives of FDI are under review also.

To refuse to pay all or any part of our 1987 subscription will eventually lead to the removal of Canada from FDI. I feel this would have serious political repercussions from our own membership. Canada cannot weigh "how much do we get out of FDI" against our costs since we give to an international organization our expertise rather than take from them. It is truly an international obligation. From a membership point of view, removing the opportunity to travel and partake in annual world congresses would not be taken lightly.

1987 FDI ANNUAL SUBSCRIPTION REPORT

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Our 1985 total FDI expenditure (and probably our 1986 expenditure) represents approximately 1.1 % of our total annual expenditures. With the 1987 annual subscription increase, approximately 1.3 % of our budget will represent FDI costs.

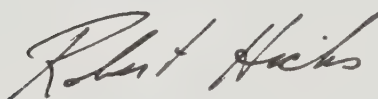
RESOLVED:

87.8 THAT CDA continue to support and participate in the area of international dentistry and FDI for 1987; and,

THAT the 1987 FDI Annual Subscription of U.S. \$17,034 be approved.

ADOPTED

Respectfully submitted,



Robert N. Hicks, D.D.S., M.S.
FDI National Treasurer

ADOPTION OF REPORT

The Board of Governors receives the report on the 1987 FDI Annual Subscription with appreciation.

COMMENTS ON THE FDI BUDGETS FOR 1986 AND 1987THE ACCOUNTS FOR 1985

These accounts showed an excess of income over expenditure of \$34,392 compared with the budgeted surplus of \$17,380 for 1985 and an excess of income of \$114,375 in 1984. Income at \$640,784 was \$75,066 less than budgeted, whilst expenditure at \$606,392 was \$92,078 less than budgeted.

The loss in income was largely due to the lower than expected attendance at the 73rd Annual World Dental Congress in Belgrade in September 1985. The depreciation of the Yugoslav dinar against the US dollar also meant that the Federation received less from its 15% of the fees paid by the 967 Yugoslav dentists in their own currency. The Federation's income from the congress was therefore \$51,269 instead of the \$107,250 which had been budgeted.

* Income from supporting membership was also unfortunately less than budgeted, \$197,366 compared with \$228,600. Small drops in membership are usually counteracted by the new members attending the annual world dental congress. That was not the case in 1985.

* The compensating reduction in expenditure in 1985 was again due to the favourable exchange rate between the US dollar and sterling which averaged 1.29 for the year as against the budget preparation figure of 1.60. That fact again produced large savings, particularly in the Headquarters office where about 60% of the annual expenditure occurs. The cost of the office in 1985 was \$304,142 as compared with the budget of \$327,000.

Expenditure on the Newsletter is also incurred mainly in sterling and there was a saving of \$17,534 on this item in 1985.

Whilst the Federation makes savings in expenditure when the value of the pound drops against the US dollar as it did in 1985, it suffers when the pound strengthens. (See Appendix 1.)

All organizations - large, medium or small - which are involved in international activities with collection of subscriptions in one currency and payments for services and goods in other currencies are highly vulnerable to fluctuations in exchange rates.

That is the reason why organizations like the FDI have to adopt quite a conservative approach to the rate of exchange they select between the US dollar and the pound sterling for budgetary purposes. Quite obviously by adopting that policy the Federation may find itself with some collateral income by the end of the financial year. This has been utilized to avoid, or keep down, increases in the subscriptions of the member associations and supporting members and the International Dental Journal. However, even by taking that approach, the Federation has at times incurred heavy losses due to the rate of exchange adopted, as happened in 1980.

1986 BUDGET

Expenditure to 30 June on most line items is within the budget which was prepared at a rate of exchange figure of \$1.60 to the pound, whilst the average for the first six months is \$1.47. Enrolments for the Manila congress have been delayed by the uncertain situation in the Philippines earlier in the year, but it is hoped that the Federation will receive the income budgeted.

1987 BUDGET

This has been prepared at a rate of exchange of 1.75. Sterling's trading range against the dollar in 1986 is 1.37 to 1.5555. The Executive Committee therefore considered it prudent to allow for a further fluctuation of 20 cents in 1987.

Using this exchange rate unfortunately has a dramatic effect on the 1987 budget, turning increased expenditure in the headquarters office of 16.14% in sterling (which will be explained later) into an increase of 26.96% in dollars.

INCOME BUDGET

1. The figure of \$380,000 for income from member associations in the 1987 budget is an unprecedented increase of 32.86% on the 1986 figure. A computer print-out is attached showing the subscriptions which will be due from member countries in 1987. The membership figures have been updated this year. The Executive Committee agreed that in the case of countries which did not supply their latest membership figures, 10% should be added to the previous figure. The national per capita income figures are taken from the World Bank Atlas 1986.

The main source of income for the Federation should come from the subscriptions of member associations as this is the only income which can be budgeted accurately. For the last few years these subscriptions have not been increased sufficiently to keep pace with the Federation's expanding commitments.

2. Income from Supporting Members in 1987 is based on 12,000 members paying a subscription of \$20. The subscription has not been increased for six years. In view of the current trend in exchange rates it seems an opportune time to make this small increase which may have little or no effect on the subscription when converted into many other currencies. Supporting membership fell from 12,042 in 1984 to 10,991 in 1985, but the Executive Committee felt that this is not due to the amount of the subscription but to other factors. The Executive Committee debated whether the marketing programme which will be launched in Manila is likely to result in greatly increased income from supporting members in 1987, but decided that the increases were more likely in 1988.
3. The income figure for the International Dental Journal has been reduced by \$4,000 to \$26,000. The difference in exchange rate will also affect the journal which is printed in the United Kingdom. It is proposed to increase the Journal subscription for supporting members to \$30 from 1 January 1987.

No significant increase in Journal circulation is anticipated in 1987. However, changes in policy and layout are being studied by the Editor and the Publications Committee which may eventually lead to an increase in income.

4. Interest on investments has been reduced by \$10,000 because of the drop in interest rates on bank deposits.
5. Anticipated income from the annual world dental congress is down by \$15,000. The income of \$105,000 from the Buenos Aires Congress is based on the budget submitted by the Organizing Committee. The estimated attendance is 3,008 dentists and 600 accompanying persons. The FDI will receive 15% of the enrolment fees.

EXPENDITURE BUDGET

9. ~~X~~ Officers Expenses: Because of the serious budgetary situation no increases are proposed in 1987 in the expense allowances for the President, President-Elect and Treasurer.

On retiring from the office of President in 1985, Dr J Jardiné drew attention to the fact that private practitioners who accept office in the FDI suffer a loss of income for which they are not indemnified. He pointed out that that could restrict the choice of officers in future. In view of the budgetary situation for 1987 it is still not possible to offer any reimbursement for these losses.

10. ~~X~~ No increase is recommended in the Executive Director's salary and expenses in 1987 because of the budget constraints.

11. The budget for the Headquarters Office is calculated in sterling. The increase in expenditure in this currency is 16.14%, but this becomes an increase of 26.96% when converted into dollars at an exchange rate of 1.75.

It is likely that the 1986 budgets for salaries and disability insurance will be overspent. Since the Belgrade congress there have been five changes in staff due to retirement, maternity and other reasons. Good replacements have been found and the opportunity has been taken to turn two part-time positions into full-time jobs in order to provide more secretarial capacity and more and better qualified assistance with the financial administration in preparation for the retirement in 1990 of the Assistant Executive Director.

Apart from the Executive Director, the Federation still employs only ten full-time and one part-time staff. That is a very small number compared to most of the larger national dental associations and salaries in London are still lower than those in most other European capitals.

- ~~X~~ Other line items which have been increased substantially in 1987 are office supplies and depreciation. This is necessitated by increased production and the costs related to the computerization of the Federation's accounts.

The Federation's present favourable lease with the British Dental Association extends to October 1988. However the FDI is now very short of space and must continue to investigate the possibilities of purchasing its own building.

Appendix 4 is attached to show the expenditure in 1984 and 1985 and Budgets for 1986 and 1987 in sterling and dollars.

12. Newsletter As a result of obtaining competitive quotations from several printers only a small increase is anticipated in printing costs in 1987. Since the FDI assumed responsibility for soliciting advertising, income has increased substantially and the budget for 1987 is \$17,000 compared with \$5,000 for 1986. It is therefore anticipated that total expenditure on the Newsletter will drop from \$92,700 in 1986 to \$88,200 in 1987.
13. Council expenses Only one four-day meeting has been scheduled for the Executive Committee in 1987.

14. The cost of the travel to the annual congress of members of the Council, the Chairmen and Vice-Chairmen of Commissions and the Scientific Programme.
17. Committee and the eight members of staff required at the congress is based on the arrangement whereby organizing committees have to negotiate 35 free hotel rooms and free or reduced flights on their national airlines.
20. Finally it should be noted that General Contingencies \$15,000, Provisions
21. for exchange fluctuations \$15,000 and the Headquarters contingency fund \$6000 give a total of \$36,000 which is 4.41% of the total expenditure budget.

Conclusion

In drawing up the 1987 draft budget the Executive Committee was confronted with serious problems. Firstly the exchange rate between the dollar and the pound sterling which has worked in the Federation's favour during the past two years has now swung the other way. Secondly the Federation's income from supporting members, the world congress and investments may be less in 1987 than 1986 which means that the only possibility to meet the anticipated increase in expenditure is to raise considerably the subscriptions from the member associations.

The Council has in the past endeavoured to keep the increase in subscriptions from member associations to the absolute minimum, realizing that some of them have their own budgetary problems. This has meant that the Federation has not been able to build up the reserves which it now needs.

The Executive Committee studied very carefully the proposed budget for the headquarters office for 1987 and is convinced that the greatest economies are being made which are consistent with providing the multi-lingual service that the FDI should give its members.

As mentioned on page 2, it is proposed to launch a marketing programme in Manila. The American Dental Association is very kindly making available to the FDI the help and advice of Mr B Roach, one of its Assistant Executive Directors who heads the ADA Division of Communications. He visited the headquarters office in March to study the Federation's administration and submitted to the Executive Committee at its meeting in May a very good report which aims at:

1. Increasing the number of supporting members of the FDI;
2. Increasing the contributions of Friends of the FDI or other corporate gifts; and
3. Increasing the number of subscribers to the International Dental Journal.

He will be discussing his proposals with the Council in Manila and has been asked to make a presentation to the National Treasurers to assist the Treasurers in countries where the FDI has had little success in the past in recruiting supporting members, but where it is considered that there is potential for the future.

The Finance Committee will also be looking again at a formula for discounting the subscriptions of member associations where there is an increase in the number of supporting members.

The Federation will require funds in 1987 to carry out the programmes proposed by Mr Roach and the Executive Committee therefore hopes that the member associations will agree to bear the exceptional increase in their subscriptions next year. Every effort will be made to ensure that the marketing programmes are successful so that such a substantial increase is not needed again.

The Treasurer or the Executive Director will be pleased to provide further information on any item in the 1987 draft Budget.

I hope you will understand the difficult financial situation with which we are faced and help to keep the Federation financially viable.

RUPERTO GONZALEZ GIRALDA
FDI TREASURER

CURRENCY CONVERSION RATES \$/£(*)			
	1 9 8 4	1 9 8 5	1 9 8 6
JANUARY	1.451	1.159	1.445
FEBRUARY	1.406	1.12	1.412
MARCH	1.49	1.08	1.447
APRIL	1.441	1.222	1.484
MAY	1.398	1.227	1.52
JUNE	1.383	1.286	1.474
JULY	1.35	1.305	1.532
AUGUST	1.30	1.409	—**
SEPTEMBER	1.293	1.392	—
OCTOBER	1.235	1.420	—
NOVEMBER	1.22	1.443	—
DECEMBER	1.159	1.440	—
MEAN YEAR AVERAGE	1.343	1.291	1.473
ACTUAL BUDGET FIXED IN MAY OF PREVIOUS YEAR	1.80	1.80	1.60
% DIFFERENCE	34.028%	39.427%	8.622%

*at 1st day of month. Source: Financial Times

**CHART prepared at 31st July 1986

FEDERATION DENTAIRE INTERNATIONALE

INCOME BUDGET

	<u>Budget</u> 1985	<u>Income</u> 1985	<u>Budget</u> 1986	<u>Budget</u> 1987
(exchange rate dollar to pound)	(\$1.80)	(\$1.29)	(\$1.60)	(\$1.75)
1 Subscriptions - Member Associations	275,000	275,502*	286,000	380,000
2 Subscriptions - Supporting Members	228,600	197,204	225,000	240,000
3 International Dental Journal	30,000	27,363	30,000	26,000
4 Interest on Investments/banks	44,000	60,201	55,000	45,000
5 Annual World Dental Congress	107,250	51,269	120,000**	105,000**
6 Grants from Friends of FDI	30,000	25,614	35,000	50,000
7 Publications income (net)	1,000	3,503	2,000	5,000
8 IDSO (Annual retainer £15,000)	-	-	-	-
	715,850	640,656	753,000	851,000
Expenditure	698,470	606,401	761,515	851,000
Excess of income over expenditure	17,380	34,255		
Excess of expenditure over income			8,515	

EXPENDITURE BUDGET

9 Officer's expenses	21,000	21,698	26,000	26,000
10 Executive Director's salary & exp	67,700	65,366	68,200	68,200
11 Headquarters office	327,000	304,142	359,150	456,000
12 Newsletter	84,600	67,066	92,700	88,200
13 Council expenses	60,840	56,035	60,600	62,600
14 Commissions	37,730	25,949	44,645	40,450
15 Regional org. and secretariats	4,000	3,000	5,500	3,500
16 International Dental Journal	8,500	7,232	7,100	11,050
17 Annual Congress and Gen. Ass.	44,200	36,893	52,220	48,500
18 Membership and grants	2,400	2,903	2,400	2,500
19 Consultancies & legal fees	13,000	16,090	13,000	14,000
20 Provision for exchange fluctuations	17,000	(9,062)	18,000	15,000
21 General contingencies	10,500	8,133	12,000	15,000
22 Subscriptions written off		956		-
	698,470	606,401	761,515	851,000

* Including \$8,175 paid into FDI non-transferable accounts in Eastern Europe

** The Manila Congress budget now includes \$106,000 as the FDI 15% based on an attendance of 3,766 dentists and 800 Accompanying persons.

Buenos Aires income is based on 3008 dentists and 600 accompanying persons.

N.B. The SM budget is based on 12,500 x \$18 in 1986 and 12,000 x \$20 in 1987

EXPENDITURE 1985, BUDGET FOR 1986 AND RECOMMENDED BUDGET FOR 1987

<u>Budget Item</u>	<u>EXPENDITURE 1985</u> (\$1.29)	<u>BUDGET 1986</u> (\$1.60)	<u>BUDGET 1987</u> (\$1.75)
<u>PRESIDENT'S EXP.</u>	13,043	15,000	15,000
<u>PRESIDENT-ELECT'S EXP</u>	5,463	6,500	6,500
<u>TREASURER'S EXPENSES</u>	3,192	4,500	4,500
<u>EXEC.DIR. SALARY AND</u>	56,700	56,700	56,700
<u>TRAVEL/ENTERTAINMENT</u>	8,666	11,500	11,500
	<u>87,064</u>	<u>94,200</u>	<u>94,200</u>
<u>HEADQUARTERS OFFICE</u>			
Salaries (10 full, 2 part-time staff)	153,022	186,350	226,200
Disability insurance	5,801	8,000	14,000
Pension Plan	20,441	33,000	40,000
Office supplies	26,241	24,800	43,000
Rent, rates	34,632	48,000	53,400
Postage	9,014	14,400	14,500
Telephone	10,038	12,000	15,000
Promotion	15,243	2,400	8,000
Staff Travel	4,268	3,200	4,300
Depreciation	16,040	15,000	21,000
HQ Contingency fund	5,495	6,000	9,600
Computerization of membership records	<u>3,907</u>	<u>6,000</u>	<u>7,000</u>
	304,142	359,150	456,000
<u>NEWSLETTER</u>			
Printing	30,400	47,000	50,000
Sals for writing and translating	12,716	23,500	29,500
Postage, packing	24,154	27,500	26,000
Less sales	(204)	(300)	(300)
Less advertising	<u>-</u>	<u>(5,000)</u>	<u>(17,000)</u>
	67,066	92,700	88,200
<u>COUNCIL EXPENSES</u>			
<u>Executive Committee</u>			
Meeting expenses	1,981	1,800	2,000
Travel	<u>5,898</u>	<u>6,400</u>	<u>9,000</u>
	7,879	8,200	11,000
<u>Sc.Prog Committee</u>			
Clerical	757	1,200	1,250
Telephone	125	200	200
Postage	249	500	500
Travel	4,550	4,500	3,600
Office supplies	100	300	300
Questionnaire	<u>402</u>	<u>-</u>	<u>350</u>
	6,183	6,700	6,200
	<u>14,062</u>	<u>14,900</u>	<u>17,200</u>
	<u>458,272</u>	<u>546,050</u>	<u>638,400</u>

	<u>EXPENDITURE 1985</u>		<u>BUDGET 1986</u>		<u>BUDGET 1987</u>	
Brought forward	14,062	458,272	14,900	546,050	17,200	638,400
<u>Committee on Coms.</u>	2,338		2,350		7,400	
<u>Elective officers travel</u>						
to annual congresses	24,902		24,850		20,000	
<u>Representation</u>	3,404		7,500		5,000	
<u>Audit</u>	11,329	56,035	11,000	60,600	13,000	62,600
<u>COMMISSIONS</u>						
<u>CORE</u>						
Clerical expenses	260		500		500	
Telephone and cable	245		400		400	
Postage	241		400		400	
Travel	4,358		4,875		6,200	
Office supplies	210		400		400	
Working Groups	202		3,000		2,000	
	<u>5,516</u>		<u>9,575</u>		<u>9,900</u>	
<u>DENTAL EDUCATION & PRACTICE</u>						
Clerical expenses	309		1,500		1,500	
Telephone	396		400		400	
Postage	114		600		600	
Travel	3,510		6,340		5,300	
Office supplies	37		400		400	
Working Groups	692		1,750		1,750	
	<u>5,058</u>		<u>10,990</u>		<u>9,950</u>	
<u>DENTAL PRODUCTS</u>						
Clerical expenses	1,200		1,500		1,200	
Telephone	105		250		250	
Postage	964		2,000		2,000	
Printing	895		1,200		1,200	
Travel	5,011		7,000		5,800	
Office supplies	707		800		800	
Working Groups/SAs	1,850		2,500		3,000	
	<u>10,732</u>		<u>14,950</u>		<u>14,250</u>	
<u>DEFENCE FORCES</u>						
Clerical	300		120		120	
Telephone	200		120		150	
Postage	100		70		80	
Printing	497		1,100		200	
Travel	2,496		6,000		4,000	
Office supplies	-		-		-	
Working Groups	330		220		300	
	<u>3,923</u>		<u>7,630</u>		<u>4,850</u>	
	<u>25,229</u>		<u>43,145</u>		<u>38,950</u>	
		<u>514,307</u>		<u>606,650</u>		<u>701,000</u>

	<u>EXPENDITURE 1985</u>		<u>BUDGET 1986</u>		<u>BUDGET 1987</u>	
Brought forward	25,229	514,307	43,145	606,650	38,950	701,000
<u>INCOGUDET</u>	<u>720</u>	25,949	<u>1,500</u>	44,645	<u>1,500</u>	40,450
<u>REGIONAL ORGANIZATIONS</u>						
ERO	-		-			
APRO	-		-		-	
LARO	<u>1,000</u>	1,000	<u>1,000</u>	1,000	<u>-</u>	nil
<u>SECRETARIATS</u>						
SEDHA	-		1,000		-	
SESDA	2,000		2,000		2,000	
SOUTH PACIFIC	-		-		-	
CARDA	<u>-</u>	2,000	<u>1,500</u>	4,500	<u>1,500</u>	3,500
<u>EDITOR INT.DENTAL JOURNAL</u>						
Clerical	1,805		1,850		1,950	
Telephone & postage	135		250		250	
Travel	880		1,500		4,100	
Office supplies	708		500		750	
Translations	<u>3,704</u>	7,232	<u>3,000</u>	7,100	<u>4,000</u>	11,050
<u>ANNUAL CONGRESS AND GENERAL ASSEMBLY</u>						
Exec. Dir.Assistants	4,053		8,260		6,000	
Staff	7,225		9,760		9,000	
Refreshments	6,896		7,000		7,000	
Stenotypist	6,378		8,500		11,500	
Recep.for Org.Com.	-		-		-	
Production and mailing of documents	6,512		10,700		10,000	
Interpretation for WGs*	5,829	36,893	<u>8,000</u>	52,220	<u>5,000</u>	48,500
<u>MEMBERSHIP AND GRANTS</u>		2,903		2,400		2,500
<u>CONSULTANCIES AND LEGAL FEES</u>		16,090		13,000		14,000
<u>GENERAL CONTINGENCIES</u>		8,133		12,000		15,000
<u>PROVISION FOR EXCHANGE FLUCTUATIONS</u>		(9,062)		18,000		15,000
<u>SUBSCRIPTIONS WRITTEN OFF</u>		<u>956</u>		<u>-</u>		<u>-</u>
		<u>606,401</u>		761,515		<u>851,000</u>

Appendix 4

HQ OFFICE	<u>1984</u>		<u>1985</u>		<u>1986</u>		<u>1987</u>	
	£	(\$1.35) \$	£	(\$1.29) \$	£	(\$1.60) \$	£	(\$1.75) \$
<u>Annual average rate</u>								
Salaries	95,513	127,863	116,353	153,022	116,500	186,350	129,400	226,200
Dis Pension	3,265	4,364	4,450	5,801	5,000	8,000	8,000	14,000
Pension	12,730	17,720	16,306	20,441	20,625	33,000	22,900	40,000
Supplies	19,045	25,598	20,477	26,241	15,500	24,800	24,600	43,000
Rent & Rates	24,899	35,275	27,889 *	34,632	30,000	48,000	30,500	53,400
Postage	6,646	9,002	6,994	9,014	9,000	14,400	8,250	14,500
Telephone/telex	5,200	6,774	7,547	10,038	7,500	12,000	8,500	15,000
Promotion	2,115	2,811	11,446 **	16,040	1,500	2,400	4,600	8,000
Staff Travel	3,412	4,085	3,277	4,268	2,000	3,200	2,500	4,300
Depreciation	10,252	13,840	11,816	15,243	9,375	15,000	12,000	21,000
Contingencies	1,402	1,714	4,233	5,495	3,750	6,000	5,500	9,600
Sale of assets		(1,018)						
Computerization	2,561	2,995	2,718	7,531	3,750	6,000	4,000	7,000
	£182,604 (+11%)	\$251,024 (+0.17%)	233,506 (+28.23%)	304,142 (+21.57%)	224,500 (-3.85%)	359,150 (+18.08%)	260,750 (+16.14%)	456,000 (+26.96%)

* Rent - £10,000 per annum. October 76-79
£15,000 per annum. October 79-82
£18,750 per annum. October 82-85

Rent - £22,500 per annum. October 85-88
**£10,837 on printing promotion leaflets

TOTAL INCOME 380000		CEILING = 20 %		INCLUDING USA	
COUNTRY A	MEMBERS B	PCI C	FACTOR A D=B.C	FACTOR C E=FZ	REV SUB F
USA	127633	15490	1977035170	20.000	76000
JAPAN	41893	10390	435268270	16.114	61165
GERMAN FED REP	31284	11090	346939560	12.868	48898
FRANCE	19948	9860	196687280	7.327	27843
UK	16708	8530	142519240	5.329	20251
CANADA	9099	13140	119560860	4.483	17034
SWEDEH	7948	11880	94422240	3.555	13509
AUSTRALIA	5913	11890	70305570	2.664	10125
DENMARK	4948	11290	55862920	2.131	8098
NETHERLANDS	5707	9430	53817010	2.056	7813
ITALY	8135	6440	52389400	2.004	7614
NORWAY	3541	13750	48688750	1.867	7095
GERMAN DEM REP	6200	7045	43679000	1.682	6392
SWITZERLAND	2700	15990	43173000	1.664	6322
FINLAND	3655	10830	39583650	1.531	5819
ARGENTINA	16380	2230	36527400	1.418	5390
GREECE	7720	3740	28872800	1.135	4314
USSR	19955	1323	26400465	1.044	3966
SPAIN	5141	4470	22980270	0.917	3486
AUSTRIA	2200	9140	20108000	0.811	3082
VENEZUELA	5060	3220	16293200	0.670	2545
POLAND	7259	1851	13436409	0.564	2143
ISRAEL	2172	5100	11077200	0.477	1811
BELGIUM	1299	8430	10950570	0.472	1793
NEW ZEALAND	1091	7240	7898840	0.359	1363
KOREA	3376	2090	7055840	0.328	1245
HUNGARY	3417	2050	7004850	0.326	1238
YUGOSLAVIA	3000	2120	6360000	0.302	1147
CZECHOSLOVAKIA	2200	2573	5660600	0.276	1048
SOUTH AFRICA	2117	2260	4784420	0.243	925
HONG KONG	748	6300	4712400	0.241	915
URUGUAY	2208	1970	4349760	0.227	864
KUWAIT	282	15410	4345620	0.227	863
IRAQ	2192	1730	3792160	0.207	785
CHILE	1900	1710	3249000	0.187	709
COLOMBIA	2343	1370	3209910	0.185	703
IRELAND	605	4950	2994750	0.177	673
SINGAPORE	387	7260	2809620	0.170	647
LUXEMBOURG	157	13650	2143050	0.146	553

TOTAL INCOME 380000		CEILING = 20 %		INCLUDING USA	
COUNTRY A	MEMBERS B	PCI C	FACTOR A D=B.C	FACTOR C E=FI	REV SUB F
PORTUGAL	1065	1970	2098050	0.144	547
CUBA	2906	707	2054542	0.142	540
PERU	1940	980	1901200	0.137	519
ICELAND	198	9380	1857240	0.135	513
UNITED ARAB EMIRATES	30	22300	1784000	0.132	502
PHILIPPINES	2500	660	1650000	0.127	483
SYRIA	847	1870	1583890	0.125	474
THAILAND	1658	850	1409300	0.118	449
INDONESIA	2300	540	1242000	0.112	426
MALAYSIA	600	1990	1194000	0.110	419
IRAN	419	2584	1082696	0.106	403
BULGARIA	495	2135	1056825	0.105	400
CYPRUS	275	3590	987250	0.103	390
LEBANON	513	1610	825930	0.097	367
INDIA	3084	260	801840	0.096	364
JORDAN	442	1710	755820	0.094	357
GUAM	43	6580	282940	0.026	100
MALTA	36	3370	121320	0.026	100
MOROCCO	181	670	121270	0.070	267
NIGERIA	121	770	93170	0.069	263
BARBADOS	20	4340	86800	0.026	100
BAHAMAS	20	4260	85200	0.026	100
EGYPT	111	720	79920	0.069	261
BURMA	411	180	73980	0.053	200
ZIMBABWE	63	740	46620	0.053	200
BANGLADESH	350	130	45500	0.053	200
KENYA	133	300	39900	0.053	200
HAITI	60	320	19200	0.053	200
SENEGAL	46	380	17480	0.026	100
ZAMBIA	35	470	16450	0.026	100
ZAIRE	75	170	12750	0.053	200
TANZANIA	40	210	8400	0.026	100
SIERRA LEONE	23	300	6900	0.026	100

AD HOC COMMITTEE ON MEMBERSHIP

REPORT TO THE 1987 CDA INTERIM BOARD OF GOVERNORS

Members: Dr. P. Ralph Crawford, Chairman, Winnipeg
Dr. Bradley W. Holmes, Kenora
Dr. Kevin L. Roach, Pembroke
Dr. Gilles Dubé, Lachute

Meetings

The Ad Hoc Committee met in Ottawa on Friday, January 9, 1987.

ITEMS REQUIRING BOARD ACTION

I. GOALS AND OBJECTIVES

Dr. Crawford and Mr. Neal reviewed the activities of the membership over the past few years. They stressed that the past efforts were worthy and productive - CDA Membership had "held its own and even increased last year" - but due to the added pressures on volunteer provinces for membership dollars, a more concentrated program was required; goals needed to be re-emphasized and a new committee structure established that would give both continuity and flexibility.

RESOLVED:

87.9 THAT the stated goals and objectives of the Membership Committee be approved:

- 1) To improve communications between the Association and provincials associations.**
- 2) To be active in the dissemination of information pertaining to the activities, programs and plans of the Association.**
- 3) To be active in the improvement of membership services.**

.../2

AD HOC COMMITTEE ON MEMBERSHIP

- 4) To increase the number of volunteer spokespersons and promote CDA membership with their help.
- 5) To encourage membership in the CDA from students, new graduates and the established dentists in the voluntary provinces of Quebec and Ontario.
- 6) To increase the voluntary membership in Ontario and Quebec annually by at least the percentage increase in the total number of dentists.

ADOPTED

II. TERMS OF REFERENCE

RESOLVED:

87.10 THAT the following TERMS OF REFERENCE for the Membership Committee be approved:

- 1) The Membership Committee remain a Committee of Executive Council.
- 2) The Chairperson position be renewable, on an annual basis. There is a definite need for continuity in the position, and for that matter, in the Committee itself,
- 3) The balance of the Committee would not exceed five (5) people, meeting the following criteria:
 - Mandatory province representation.
 - Quebec Executive Council member.
 - Ontario Executive Council member.
 - A recent graduate from a Canadian dental school

AD HOC COMMITTEE ON MEMBERSHIP

- 4) The Committee meet twice a year in or around the months of May and October.

ADOPTED

DIRECTION: The Council on Constitution and By-Laws was directed to make the appropriate by-laws amendments.

III. SURVEY

In preparation for the 1988 Campaign, it is necessary to obtain reliable market data that would establish information as to the numbers of dentists eligible for membership; why they had - or had not joined CDA; why they ceased to be members and what would entice them to rejoin. The current data in CDA membership files was to be reviewed, as was a recent membership survey by the ADA.

RESOLVED:

87.11 THAT the CDA conduct a survey of recent graduates and dentists whose membership status had changed within the past five (5) years (i.e. they had either joined or dropped their CDA membership during the last five (5) years).

THAT the survey include a comparison of a larger metropolitan center to smaller centers in order to gauge whether or not there is in fact a difference in the attitude towards membership depending upon geographic location.

ADOPTED

NOTE: It is calculated that such a survey would cost approximately \$5,000, and that amount had already been included in the 1987 Budget.

IV. BY-LAW CHANGES

The Ad Hoc Committee recommends the following by-law changes:

RESOLVED:

- 87.12 THAT the amount payable by the corporate member be based on an accounting of the number of members in that corporation the previous year and that such a payment fall due on March 1 of the calendar year, and further that changes to the number of members in the corporation in the current year be forwarded to the CDA on or before October 1 of the calendar year and that any adjustment to the fee be made within 30 days of such notice.

TABLED

DIRECTION: Discussion continue with the Corporate Members as to modalities of payment of their fees to the CDA. The Council on Constitution & By-Laws will be consulted.

RESOLVED:

- 87.13 THAT the policy regarding the payment of dues by students graduating during a calendar year, wherein upon joining CDA, they are obliged to pay only one half the annual dues, be incorporated into the by-laws and that further such a policy apply to all dentists who apply for membership in the Canadian Dental Association for the first time, following June 30 of a calendar year.

WITHDRAWN

DIRECTION: The above motion was withdrawn as a by-law amendment was considered unnecessary. The above statement is to be incorporated into the administrative policy/procedures of CDA.

RESOLVED:

- 87.14 THAT, with regard to the allocation of seats on the Canadian Dental Association Board of Governors, the corporate body be obligated to submit a list of members of the corporate body to the CDA on or before June 30 of the given year.

ADOPTED

AD HOC COMMITTEE ON MEMBERSHIP

- 5 -

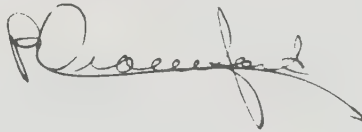
RESOLVED:

- 87.15 THAT, with regard to the Board count, life members (licensed or non-licensed) no longer be considered in the count of members regarding allocation of Board seats.

DEFEATED

NOTE: Further information will be obtained from Corporate Bodies and the Council on Constitution and By-Laws.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read 'P. Ralph Crawford', with a long, sweeping horizontal stroke extending to the right.

P. Ralph Crawford, D.M.D.
Chairman
Ad Hoc Committee on Membership

ADOPTION OF REPORT

The Board of Governors accepts the report of the Membership Committee with appreciation.

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. B.W. Holmes, Chairman, Kenora
 Mrs. Pat Johnson, Willowdale
 Dr. K.C. Bentley, Montreal
 Dr. Bill Bedford, Ottawa
 Dr. Robert Salois, Sherbrooke
 Rev. Rondo Thomas, Scarborough

1. Committee Meetings

Since the 1986 Annual Meeting, the Committee has met twice, on November 14, 1986 and January 10, 1987. The Committee also held discussion via a conference call on January 26, 1987.

ITEMS OF INFORMATION - NOT REQUIRING BOARD ACTION

2. Demand Side Study

As reported at the 1986 Annual Meeting, the CDA commissioned Dr. Ron House of R.K. House & Associates to conduct a study of the demand for dental professional services through to the year 2006.

Procedure frequencies, by age group for both high care, and average-care patients for 1986 were developed by Dr. House, using data from a variety of sources.

These procedure frequencies were presented to the demand side research group, which was composed of:

Garry Jackson	Dalhousie University
Jean-Paul Lussier	Laval University
Stan Kogan	University of Western Ontario
Ernie Ambrose	University of Saskatchewan
Charlie Baker	University of Alberta
Brian Rocky	College of Dental Surgeons of B.C.
Don Lewis	University of Toronto
Ron House	York University
Frank Edwards	Inglewood, Ontario

.../2

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

In selecting the group regional representation, availability and academic backgrounds (due to impact on knowledgeability re new techniques) were considered.

The following six sets of scenarios were developed by the group:

Scenario #1 Under this scenario it was assumed that the decline in the caries rate has "bottomed out" but that the impact of the decline in caries would have an impact on the demands for service for the relevant age cohorts in future years. The older age cohorts are assumed to have essentially similar care requirements as those preceding them. It was further assumed that there would be no significant changes in technology.

Scenario #2 Under this scenario it was assumed that the decline in the caries rate had not necessarily "bottomed out" and that further declines in the caries rate were possible. When addressing this scenario, each participant had to determine what further decline, if any, would take place. The specific data presented here represents the consensus of the group, thus the initial assumption any one individual may have made was modified through discussion with other members of the team. This scenario for future years therefore reflected the impact of the decline in caries that has already taken place on the relevant age cohorts in the future and further decline within the youngest age cohorts. The demand for discretionary service was assumed constant.

Scenario #3 This scenario assumed the same epidemiological pattern as Scenario #2 but allowed for variation in the frequency of discretionary procedures. The discretionary procedures were identified as those procedures which are not "disease driven" such as the diagnostic, preventive and possibly cosmetic services. It was recognized that if the evidence of disease changes over time, patient and dentist may revise their notion of the required frequency of diagnostic examination, radiographs and so forth. Scenario #3 was designed to reflect these possible changes.

Scenario #4 was intended to build upon Scenario #3 by assuming the same underlying frequency of disease and discretionary procedures but was to allow for changes in dental material and techniques. This is particularly important for the older age groups because much of the work done in the upper age groups is, in fact, related to the maintenance or replacement of previous restorations. In this scenario, the research group therefore addressed the question of whether procedures and material currently being introduced or under experimentation would significantly alter the life of restorations and therefore the replacement rate.

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

Scenario #5 was intended to expand upon Scenario #4 by speculating on major changes in techniques for prevention and restoration. The research group came to refer to this as the "magic bullet" scenario and eventually concluded that it was not possible to meaningfully speculate about the potential impact of such things as vaccines, chemotherapy and so forth.

Scenario #6 was intended to broaden Scenario #5 by including any factors that had been neglected in the development of the first five scenarios. Like Scenario #5, it was ultimately dropped as being too speculative.

There was consensus among the participants on the definition of procedure groups, age groups, under lying assumptions for each scenario and the use of baseline data prepared by R.K. House and Associates. Participants were then asked to prepose their own estimates of the procedure frequencies for the 6 scenarios for the year 2006. At a second meeting, a consensus was reached on procedure frequencies, following examination of initial independent estimates. Consensus on the first three scenarios was not difficult, however the last three scenarios presented considerable problems given highly speculative assumptions.

Procedure frequencies by age group were then paired with time and frequency studies and translated into minutes of care required by patients in the different age groups. Statistics Canada population figures were used to determine total care requirements.

A complete report on the demand study entitled "Estimating Future Dental Care Requirements - The Implications for Dental Manpower" was published in the February 1987 Journal.

APPENDIX I

Dr. House presented the study findings as well as a comparison of supply-demand statistics to the PRU Committee on November 14, 1986. Data projects an over supply of 30-50% if corrective action is not implemented.

3. Federal Provincial Advisory Committee - Health Human Resources

In keeping with the spirit of Board motion 86.67 concerning the Federal/Provincial Health Manpower Planning Group, quoted hereunder,

- 86.67 THAT the Professional Resource Utilization Committee be asked to strike a subcommittee. This subcommittee should consist of: two (2) practicing dentists, the dental consultants Dr. R.K. House and Dr. Don Lewis, with the addition of one or two members of the Health Manpower Working Group;

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

THAT the purpose of the subcommittee shall be to utilize the PRUC data and to prepare a brief on dental manpower to be presented to the Federal/Provincial Health Human Resources Planning Group;

correspondence was forwarded to Mr. J.C. Lovelace, Co-Chairman of the Advisory Committee, which resulted in a meeting with Dr. Holmes and Mr. Neilson.

APPENDIX II

CDA's current activities through the PRUC were identified, and advice sought on the potential to integrate CDA objectives with the work of the Federal Provincial Committee. CDA's proposal to integrate its work with that of the Committee, contained the provision that the Association's report also be a "stand alone" document, to be utilized as CDA deemed advisable.

Subsequently, Dr. John Dupont, Director of Health Human Resources Division - Health & Welfare Canada, attended and participated in the Committee's November 15 meeting. Since that time, Dr. Dupont has been kept up to date with all pertinent activities concerning PRUC and has agreed to facilitate the presentation of CDA reports to the Federal/Provincial Committee on Health Human Resources.

As Chairman, I am sensitive to the fact that the Board direction concerning the establishment of a sub-committee has not been carried out. However, in view of monetary constraints, and alternative methods deemed appropriate to achieving the necessary communication link, I feel the course chosen will not be detrimental to the final outcome.

4. Communicating Data on Future Forecasts of Dental Professional Resource Utilization

On Saturday, January 10, 1987 the Professional Resource Utilization Committee met for the purpose of communicating data on future forecasts of dental professional resource utilization to the Deans of the Canadian Faculties of Dentistry, to whom this information would be of ultimate significance and concern.

The Deans of the faculties of all Canadian dental schools, as well as Presidents of the Association of Canadian Faculties of Dentistry and the Canadian Dental Hygienists Association, accepted the invitation of the Canadian Dental Association. Specifically, the following attendees were thanked by Dr. Holmes for their attendance:

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Dr. Gordon Thompson	University of Alberta
Dr. George Beagrie	University of British Columbia
Dr. Arthur Schwartz	University of Manitoba
Dr. Kenneth Zakariasen	Dalhousie University
Dr. Ralph Brooke	University of Western Ontario
Dr. Richard Ten Cate	University of Toronto
Dr. Kenneth Bentley	McGill University
Dr. Alain Vaillancourt	University of Montreal
Dr. Jean-Yves Turcotte	Laval University
Dr. Peter Innes	University of Saskatchewan
Dr. Marcia Boyd	President - ACFD
Ms. Dianne Gallagher	President - CDHA

Due to the significance of the meeting to the future of the profession and the well-being of the public, CDA President Dr. John Robertson was also in attendance.

Presentation of demand and supply-demand comparisons was made by Dr. House, followed by lengthy discussion and clarification of specific areas of concern.

At the conclusion of the meeting the immediacy of the professional resource utilization problem was unanimously confirmed. The CDA agreed to sponsor a one-half day meeting of the deans of dental faculties, to be held February 21, 1987 for development of a plan for actual cutbacks in enrolment for the 1988-89 academic year. The Deans agreed to convey the message and their forthcoming recommendations to the senates, and other decision-making bodies with responsibility for enrolment levels within their universities. Mr. Neilson and Dr. Holmes will meet with the deans on the afternoon of February 21 for further deliberations. Discussion will also be held with Dr. Marcia Boyd, President of ACFD, on the ACFD Task Force on Curriculum Review.

A communiqué article and memorandum prepared following the January 10 meeting is appended.

APPENDIX III-IV

5. PRUC Recommendations

APPENDIX V

In a conference call of the PRUC held in January 26, 1987, the Committee confirmed that a 30% cutback in dental school enrolment across Canada would be the minimum level that it would endorse. In

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making this pronouncement, the Committee is cognizant of its role to act in the best interests of the public, the profession and all facets of the dental community.

A further update will be provided at the Interim Meeting of the CDA Board of Governors.

6. Appreciation

I would like to express my sincere appreciation for efforts put forth on our behalf by the members of the demand-side study. These people responded on short notice in mid Summer to a request for assistance by CDA. They accepted a challenge of considerable magnitude, working long and hard to solve it. I believe they have met their challenge admirably and for that I am most grateful.

I would also like to express my gratitude to the Deans of our ten dental faculties, who have been most co-operative in the discussions involving reduction of enrolment. I believe that they are aware of the magnitude of the problem and will help us to achieve the necessary cutbacks. I think we are on the right track and will work together to effect the necessary changes.

Respectfully submitted,



Bradley W. Holmes, D.D.S.
Chairman - Professional Resource
Utilization Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Professional Resource Utilization Committee with appreciation.

Appreciation is extended to Dr. Holmes and the Professional Resource Utilization Committee members for their outstanding achievements.

ESTIMATING FUTURE DENTAL CARE REQUIREMENTS:

THE IMPLICATIONS FOR DENTAL MANPOWER

November, 1986

The Issue

The issue of excessive dental manpower has received widespread attention throughout the western democracies. In recent years the controversy surrounding this issue has subtly, but persistently, shifted from the question of whether there is, or whether there will be excess manpower to discerning just how chronic the oversupply of dental manpower may be. With this shift in the major area of concern has come speculation about the need to reduce entry into the profession. In some countries - Sweden for example - the oversupply has led to the obviously wasteful under-employment of professional manpower; in other countries, such as Canada, the wasteful under-employment of dentists and auxiliaries is occurring but it is still disguised from public view. It is, however, a naked reality for many members of the profession, particularly the new entrants and it will gradually be perceived by the public at large as dentists and their auxiliaries have to face the harsh economics of an excess supply of manpower. Recognizing that the problem of excess manpower exists is a modest step in the direction towards its solution. Regrettably, not everyone agrees the problem exists.

Because the creation of the dental schools in the 1960's and 1970's has led to an ever burgeoning stock of dental manpower, discussion of "the problem" has concentrated largely on the supply side. An example of this is the analysis undertaken by House, Edwards and Johnson, "MANPOWER SUPPLY STUDY: Scenarios for the Future: Dental Manpower to 2001", CDA Journal, V.49, No 2, Feb. 1983. That analysis developed a model to predict "base line" estimates of dental manpower in the future using relevant parameters for dental school graduation and career patterns.

The growth of manpower predicted by the model was sufficiently dramatic that it was possible to conclude that Canada was facing a problem of excess manpower. The magnitude of this excess was not possible to establish with any degree of confidence from a consideration of the supply side alone.

To be complete, such analysis needs to be complemented by estimates of future demand for dental care.

In November of 1985, House and Edwards presented some tentative conclusions about the pattern of future demand to the C.D.A. Symposium on dental manpower. They pointed out that while their estimates may be interesting they should be treated with caution because, as economists, they were not properly qualified to speculate about the future epidemiology of dental disease. They noted, however, that surveys were revealing dramatic improvements in oral health, particularly among children and that changes in the incidence of caries appeared to have significant implications for the future demand for dental services. They expressed concern that further detailed analysis of the severity of the dental manpower issue would be seriously impeded unless acceptable estimates of future demand for dental treatment were developed.

A Workshop on Demand for Dental Services

In June of 1985, Lewis, House and Edwards, were asked by C.D.A. to convene a workshop to address the question of the future demand for dental services. The immediate purpose of this workshop was to produce estimates that could be effectively integrated into the manpower model

developed by House, Edwards and Johnson but which would also be of interest to the dental community at large.

During July and August 1986, the following participated in the Workshop:

1.	Garry Jackson	Dalhousie University
2.	Jean-Paul Lussier	University of Montreal
3.	Stan Kogon	University of Western Ontario
4.	Ernie Ambrose	University of Saskatchewan
5.	Charlie Baker	University of Alberta
6.	Brian Rocky	College of Dental Surgeons of B.C.
7.	Don Lewis	University of Toronto
8.	Ron House	R. K. House & Associates
9.	Frank Edwards	R. K. House & Associates

It was recognized that the research to be undertaken by the participants was inevitably judgemental in nature because:

- i) historic data series for either dental demand or dental needs are incomplete and open to question; and
- ii) past historic data series may not be taken as "prologue to the future" in the sense that existing trends cannot merely be extrapolated.

Some Key Concepts

The research effort required the resolution of a number of preliminary issues. The first among these was the question of whether an attempt should be made to estimate future needs or future demands. In the view of the group, the two concepts are closely related: need was regarded

as the collection of services required to restore and maintain good oral health; demand was identified as the services actually sought (and paid for) by patients. Changes in the epidemiology of dental disease which lead to changing needs ultimately have an impact upon demand. The workshop resolved the problem of the dichotomy between need and demand by recognizing that it is "effective demand" and not "need" that determines manpower requirements. The group noted, however, that the utilization rate was one critical variable in the estimation of future demand that appeared to be beyond the capability of existing data sources to resolve in a fully satisfactory manner.

Work undertaken by House and Edwards was presented to the workshop indicating that it is possible to come to varying and hence conflicting estimates of historic and current utilization rates. Because of the uncertainty surrounding current utilization rates it would be difficult to reliably estimate future utilization rates. The problems in estimating utilization rates are both empirical and conceptual. The problems become most troublesome if an attempt is made to estimate an absolute utilization rate. Many of the problems can be avoided if the analysis is conducted in terms of changes in the utilization rate.

Estimating of the utilization rate is made easier by adopting the convention of a "complete" or "high care" user. The high care user is an individual whose demand set contains virtually the complete set of continuing dental needs. Fortunately, some of the best data available exists for high care users.

The interpretation of the findings of the research group depends upon an understanding of the nature of the high care user and the perceptual

problems in defining a "utilization" rate. The two concepts are closely related.

The actual pattern of the utilization of dental services varies widely from individuals who visit the dentist every year and have all treatment needs attended to within that year, to patients that only see a dentist for emergency service, for example, an extraction. The traditional notion of utilization captured in the question "Did you visit a dentist in the past 12 months?" would treat both individuals in the same way. Their demands for dental services are, however, radically different. On the other hand an individual who visits a dentist once every 14 to 16 months (that is, less frequently than once a year) but who receives complete dental treatment will have a different utilization rate, as traditionally defined, but have treatment requirements virtually identical to those visiting the dentist once a year and also receiving full treatment.

Using data from a variety of sources, House and Edwards determined the average treatment received by high care users, by age groups. Because high care users, by definition, receive a virtually complete treatment program there is considerable similarity between this group's "demand" and its "needs". At the request of the research group the original table of treatment received by high care users presented by House and Edwards was expanded with respect to age groups. There was also a rewording and disaggregation of some procedure groups to more clearly identify the key procedure groups.

The structure of the age groups was primarily determined by the breakdown of age groups in the primary data sources; more refined

breakdowns were generally available for the younger age groups. Data for older age groups, which include third party insurance data, usually only identify "adults". Procedure time and frequency studies conducted by House and Edwards in British Columbia, Manitoba and Nova Scotia provided more specific age identification - as did reference to the Affluent Communities Studies.

House and Edwards also presented the research group with usage on demand patterns for the "average" patient. This relied primarily on dividing procedure frequency survey data by the estimated number of users that generated the data. While this approach has some arithmetic precision it is conceptually difficult to use because no meaningful definition of a utilization rate can be derived from it. Although the research group made little use of this data, it is useful if we assume no change in utilization, in estimating future percentage increases or decreases in dental care demand.

A Framework for Analysis

After preliminary discussion, the members of the research group agreed that there were various sets of assumptions under which estimates could be made and that there were grounds on which one set of assumptions could be regarded as more appropriate than the others. In view of this the groups decided to provide estimates based on each set of assumptions. Extensive discussions resulted in the identification of six sets of assumptions or "scenarios". These ranged from the first and relatively conservative set to progressively more speculative assumptions. It was felt that by examining a number of sets of assumptions, the research effort would address a broader range of

opinions about the evolution of dental needs and demands.

The six sets of assumptions identified by the research group were:

- 1) Scenario #1 The assumption for this scenario is that the decline in the caries rate has "bottomed out". This scenario addresses the impact that the recent decline in caries for the younger age groups would have on the demands for service for the relevant age cohorts in future years. The older age cohorts are assumed to have essentially similar care requirements as those preceding them. It is further assumed that there will be no significant changes in technology.
- 2) Scenario #2 The assumption for this scenario is that the decline in the caries rate had not necessarily "bottomed out" and that further declines in the caries rate were possible. This scenario is particularly relevant when taking into account the regional differences in caries experience across Canada. In addressing this scenario, each participant had to determine what further decline, if any, would take place. The specific data presented here represent the consensus of the group. The initial assumption any one individual may have made was modified through discussion with other members of the team. This scenario reflects the impact of the decline in caries that has already taken place on the relevant age cohorts in the future and the impact of a further decline in caries within the youngest age cohorts. The demand for discretionary service is assumed constant.

Scenario #3 This scenario assumes the same epidemiological pattern as Scenario #2 but allows for variation in the frequency of discretionary procedures. The discretionary procedures were identified as those procedures which are not "disease driven" such as some of the diagnostic, preventive and possibly cosmetic services. It was recognized that if the incidence of disease changes over time, patient and dentist may revise their notion of the required frequency of diagnostic examinations, radiographs and so forth. Scenario #3 is designed to reflect these possible changes.

Scenario #4 was intended to build upon Scenario #3 by assuming the same underlying frequency of disease and discretionary procedures but allowing for changes in dental material and techniques. This is particularly significant for the older age groups because currently much of the work done is related to the maintenance or replacement of previous restorations. In this scenario, the research group therefore addressed the question of whether procedures and material currently being introduced or under experimentation may significantly alter the life of restorations and therefore affect replacement rates.

Scenario #5 was intended to expand upon Scenario #4 to include major changes in techniques for prevention and restoration. The research group came to refer to this as the "magic bullet" scenario and eventually concluded that it was not possible to meaningfully speculate about the potential impact of such things as vaccines, chemotherapy and so forth.

Scenario #6 was intended to broaden Scenario #5 by including any factors that had been neglected in the development of the first five scenarios. Like Scenario #5, it was ultimately dropped as being too speculative.

To put Scenario #5 and #6 into perspective it should perhaps be noted that there was a general feeling that if it were possible to complete these Scenarios, they would lead to the conclusion that the demand for dental services as expressed in terms of professional time required would decline even further than suggested by the first three scenarios.

Estimating The Procedure Frequencies

The basic design of the research project recognized the judgemental nature of the estimates that were to be made. However, to arrive at a consensus some uniformity of approach was required. As indicated earlier, there was consensus among the participants on the definition of the procedure groups, age groups, underlying assumption for each scenario and the use of the base line data prepared by House and Edwards as a point of departure. These points of agreement were reached during an initial two day orientation meeting. Each participant was then asked to independently prepare estimates of the procedure frequencies for each scenario for the year 2006. The approach taken by each of the participants in developing their estimates appears to have varied. In certain cases it included use of computerized materials provided by Edwards and extensive consultation with University Colleagues. However, as each participant made his initial estimates there was no discussion with other members of the research group. Once these estimates were made the group reconvened for the purpose of reviewing these initial

estimates and arriving at a consensus opinion. In the discussion participants explained how they had arrived at their estimates and in some cases this led others to modify their initial estimates. Once a consensus was reached, the estimates were entered into a computer program. The participants used the computer to continuously check the consistency of the consensus estimates as the projections were developed.

The initial perception of the organizers was that the proposed task was rather daunting and that consensus might prove to be elusive. In the meeting, however, consensus was achieved rather easily. To some extent this was due to the fact that the individually prepared estimates were not radically different under the first three scenarios. The last three scenarios did, however, present problems for all members of the group and they had little confidence in their individual or collective ability to make reasonable estimates of future demands with the highly speculative assumptions. Thus estimates were prepared for Scenarios #1, 2 and 3 which are based upon observable trends and the future use of currently known materials and techniques.

The work of the research group was complete with the estimate of procedure frequencies by age group for the year 2006. This was an initial step in preparing estimates of future demand for dental manpower. The next step was to translate those procedure frequencies, or treatment requirements, into time requirements. The procedure frequency estimates were taken by House and Edwards and, using estimates of the time it takes to perform individual dental procedures derived from procedure time and frequency studies, these were translated into minutes of care required by patients in each age group. The time

estimates may be separately identified for dentists or for dental hygienists and Certified Dental Assistants.

The final step was to translate the time requirements by patient into total time requirements. The estimate of the time requirements per patient were applied to Statistic Canada's "middle" population forecasts for each of the age groups for 1986 and 2006. This gave the total care required for the entire population at 100% utilization for both the high care and average care patient.

The estimates of total time required to treat the whole population at 100% utilization will be of interest to those who have an interest in total needs rather than with total demand. The high care user has virtually all of his needs met. Extrapolating the treatment for high care users to the whole population should reflect total need. The only needs not met are those that either the practitioner, or the patient, (or both), choose to forego. Thus, for example, the need for periodontal care as expressed by procedures rendered to high care patients is lower than one would assume to be the case from the clinical field surveys that are currently available.

Without intending to offer any explanation, the authors note that there is a consistent discrepancy between the estimates of periodontal disease as identified by field surveys, and the actual provision of periodontal services under circumstances in which there would appear to be no constraints on either the dental practices' ability to provide the service or the patients' willingness to have such services performed. The judgement of the research group, therefore, is that periodontal disease cannot be expected to absorb large amounts of time. This view

is clearly at variance with one view that has been expressed that the treatment of periodontal disease could absorb a large volume of dental manpower.

A second area in which the research group believes that only very modest amounts of time will be absorbed is with respect to the treatment of Temporomandibular Joint Dysfunction (TMJ). In some circles there is an opinion that there is a very large volume of untreated T.M.J. problems that could be efficiently addressed by dentistry. The research group could find no support for this opinion and does not share it.

The Base Line Comparisons:

A matter of primary interest is of the impact that the mere change in the size and distribution of the population will have upon the demand for dental services. The relative change can be studied using either the average or high care data. Table 1 presents estimates of the procedure time requirements for high care patients for 1986 and, on the assumption of 100% utilization, develops the total time required for the treatment of each age group. This table shows the list of procedure groups down the left hand side and age groups across the top. The first figure found on this table of .79 minutes is the treatment time required in a year per patient for Comprehensive Exams for 3-4 year olds. The two columns at the right show the percentage distribution of total time to each of the procedure groups and to the four broad categories of Diagnostics, Prevention, Restoration and Other. The two lines at the bottom of the table show the population and total treatment time requirements in hours for the population in each age group.

If every Canadian received the high care of those who regularly attend the dental office, total time requirements would be 61,997,000 hours for a population of 24,484,000. Using the same procedure time requirements by age group for the year 2006 but allowing for changes in demographics it can be seen from Table 2 that total time requirements increase to 74,445,000 hours, an increase of about 20%. The total population over 3 years old will grow by 15%. The fact that total time requirements will increase faster than population growth is accounted for by the fact that the population will grow more rapidly in those age groups that require more treatment time.

It should be noted that the 1986 estimate of 61,997,000 hours is not the actual number of hours provided by dental offices; dental offices only provide services to those who actually present themselves for treatment which, of course, is only a part of the population. The difficulty here is that there are no unequivocal estimates of what percentage of the population is now receiving average care. Since the estimate of 74,445,000 is constructed in the same way as the 61,997,000 figure, the growth of 20% is reliable and can be applied, provided that it is assumed that utilization rates will be the same in both 1986 and 2006.

A comparable calculation can be made using the average care patient. Because the procedure time per person are much lower for the average patient total time is also much lower. The 1986 estimate is 46,329,000 hours and the 2006 estimate is 54,685,000 hours; this represents an 18% growth in procedure time requirements due to demographic changes.

Comparison of Base Line with Scenario #1

The procedure time estimates for high care patients under Scenario #1 are presented in Table 3. The assumption for this scenario was that the impact of the observed decline in dental caries would continue but that the trends themselves had "bottomed out". This scenario is therefore the most conservative estimate consistent with the observed changes in incidence of dental caries.

The Scenario #1 assumption reduces total time estimates from the base line 2006 projection of 74,445,000 hours to 63,854,000 hours. It can be seen that the projected base line hours are more than 16% higher than the projections under Scenario #1 in the year 2006. The decline in total time required is attributable mainly to a decline in restorative care which will be felt not only among the youngest age groups but also among the middle age groups who, in addition, may be expected to have a diminished requirement for surgical, endodontic, crown and bridge services and so forth.

This "conservative" estimate throws a new and alarming light on the dental manpower problem. Under this assumption, the decline in the individual demand for dental services largely offsets the increase in demand due to population growth and changing demographics. This estimate is based upon a mere accounting of the observed decrease in DMF rates (i.e., the number of decayed, missing and filled teeth), and other similar data for the past few decades and determining the impact of these reductions on the demand by the relevant age cohorts for dental service twenty years hence. Under these assumptions we are thus led to the conclusion that the net increase dental demand could be a very

modest 3% in total over the next twenty years. From this it may be concluded that the existing 1986 supply of manpower should be capable of providing current or improved levels of care to the population in 2006 at the existing utilization rate. To the extent that there is a currently perceived excess capacity within the profession, that excess capacity would be capable of providing dental care at an appreciable increase in the utilization rate.

Comparison of Scenario #2 with Base Line and Secenario #1

Scenario #2 relaxes the assumption that the decline in incidence of caries has bottomed out and allows each member of the research group to estimate future caries trends. It is the opinion of the group that this is perhaps the best of the estimates presented here and they are most relevant to the plan for future manpower. It is, therefore, the candidate for most extensive discussion. By comparison with the 1986 base, the Scenario #2 high care requirements will increase very modestly from a total requirement of 61,997,000 hours in 1986 to 63,437,000 hours or 2.3%. This is shown in Table 4. It may be noted that in the judgement of the research group further declines in the incidence of caries beyond that already experienced and captured in Secenario #1 will make little contribution to a further decline in the required hours. The decline may amount to about 3/4 of 1% as a result of further reductions in the caries rate among the younger age groups. The principle reason why the impact is not greater is that further reduction will only permeate a small part of the total population; the decline would be more pronounced if the study period was expanded beyond 2006. In 2006 the requirements of the 5 to 14 years old group amount to only

8.2% of the total hours required so further reduction in this age group will not have much impact on total requirements.

There will be no change in the care requirements for those over 20 years old between the assumption of Scenario #1 and Scenario #2. This arises because the care requirements for the over 20 years in the year 2006 will be established by existing level of incidence of caries for the 3 to 5 year olds and treatment received up to the time they are 20 to 25 years old. Any further declines in the incidence of caries for the younger age groups will only affect those under 20 years old by 2006. One of the primary determinants of future care requirements is the frequency of discretionary procedures (which remain unchanged between Scenario #1 and #2) and the expected life of restorations (which also remains unchanged between Scenario #1 and #2).

By contrast, there will be an absolute decline in care requirements for the under 20 year old by just over 4% as a result of the continuing downward trend in the incidence of caries.

It is interesting to contrast the present distribution of time by service with the expected distribution in 2006. The most dramatic decrease is expected to come in the provision of amalgams which will fall from 22.73% of practice time to 13.77% of practice time. The biggest increase is expected to occur in periodontics for scaling and root planing which will grow from 5.89% of practice time to 10.25%. The effect of Scenario #2 using the average patient treatment frequencies again shows a very modest growth in time requirements of just 2.8% over the next 20 years.

The consensus changes in base frequencies under Scenario 2 are shown in Table 5.

Table 6 shows the same time requirement estimates for Scenario #3. With this set of assumptions there was some increase in demand over option #2. A number of discretionary factors were taken into account in particular an increase in fluoride/remineralization for the older age groups, an increase in composite restorations for adults and an increase in TMJ treatment.

Conclusion: The work of the research group has provided an invaluable insight into the expected growth in the demand for dental services over the next twenty years. In particular it seriously challenges the notion that the demand can be expected to keep pace with the population growth. Over the next twenty years population will grow by 15%. If there were no changes in dental demands or demographics it could be inferred that demand would grow by the same rate. However, neither of these assumptions is valid. Both the demographics and the incidence of disease will change; the changing demographics creates a demand for more dental services while the impact of changes in the incidence of caries will reduce that demand.

Accounting for the impact of the changing incidence of disease, such as the reduction in caries and increase in periodontal disease, on the demand for dental services is a judgemental but necessary undertaking. If the excess manpower problem is to be held at its present levels, growth in manpower must match the growth in the effective demand for dental care. If manpower grows more rapidly we are squandering our limited educational budgets. Our best estimate is that, ceteris

paribus, demand will grow by less than 3% over the next twenty years. This is substantially below the expected growth of available manpower.

The one key issue the research group was unable to address was the possibility of changes in the utilization rate an increase in which would of course absorb more manpower. The factors affecting utilization are felt to be more economic and social than epidemiological in nature. Further study of the factors affecting the utilization rate is necessary to more precisely estimate the expected excess manpower in dentistry. The work of the research group makes it possible to take this last and final step in delineating the magnitude of one of dentistry's most pressing problems.

HIGH CARE PATIENT - TIME REQUIREMENTS IN 1986

Table 1

PROCEDURE	PROCEDURE TIME (min./patient)										TIME % DISTRIB
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+	
Comp.Exm	0.79	0.22	0.10	0.10	0.53	0.43	0.26	0.26	0.00	0.00	0.21%
Recl.Exm	12.72	14.20	16.00	13.87	15.83	15.96	17.06	17.83	13.57	13.44	10.24%
Other Exm	1.07	0.83	0.95	0.90	2.00	1.88	2.59	3.61	2.28	2.41	1.29%
Radg. 1	0.21	0.23	0.23	0.33	0.56	0.62	0.91	0.74	0.48	0.43	0.35%
Radg. 2	0.91	2.07	2.57	2.34	2.25	2.06	1.63	1.53	0.77	0.91	1.25%
Radg.Oth.	0.11	0.14	0.31	0.52	0.90	0.74	0.90	0.61	0.51	0.40	0.43%
Diag.Oth.	0.00	0.36	0.77	0.34	0.60	0.81	0.88	0.96	0.42	0.60	0.42% 14.2%
Prophy	15.57	20.70	25.76	22.37	28.51	27.70	32.31	32.92	24.43	23.85	17.83%
Fluor/Rem	5.52	7.10	8.20	5.21	2.63	2.03	2.26	1.99	1.39	1.30	2.19%
OHI	0.35	0.26	0.39	0.24	0.33	0.39	0.39	0.57	0.09	0.06	0.22%
Sealants	0.34	1.40	1.56	0.66	0.25	0.06	0.02	0.00	0.00	0.00	0.24%
Prev.Oth.	0.55	2.91	1.90	0.40	0.71	0.72	1.03	0.93	0.26	0.32	0.62% 21.1%
Amalgam	19.14	25.24	26.14	33.0	42.5	35.3	43.1	34.60	22.97	20.33	22.73%
Composite	3.14	1.90	4.69	8.23	17.40	18.29	24.59	31.75	22.00	17.85	11.04%
Crowns	0.83	0.61	0.26	1.32	8.80	12.83	18.45	20.96	8.45	3.26	6.10%
Bridges	0.00	0.00	0.06	0.72	2.65	4.87	6.01	7.57	6.16	0.15	2.18%
Rest.Oth.	0.00	0.13	0.30	1.00	2.14	2.81	2.98	5.03	4.22	0.83	1.48% 43.5%
Pulp Cap	0.03	0.01	0.02	0.02	0.08	0.08	0.05	0.02	0.02	0.02	0.03%
Cons.RCT	0.00	0.09	1.42	2.88	7.56	8.03	13.00	9.77	6.20	1.23	4.24%
Pulpotomy	0.95	0.99	0.14	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.08%
Endo Oth.	0.00	0.18	0.15	0.13	0.48	0.35	0.64	0.46	0.49	0.23	0.25%
Perio S&P	0.00	0.13	0.63	1.62	9.39	11.87	16.32	15.80	10.49	9.17	5.89%
Perio Oth	0.00	0.02	0.06	0.10	0.40	0.67	0.54	1.08	0.41	0.27	0.28%
Perio Surg.	0.00	0.00	0.00	0.02	0.42	0.37	1.10	0.43	0.63	0.00	0.25%
TMJ	0.00	0.00	0.17	1.05	1.48	0.73	1.13	1.00	0.61	0.00	0.58%
Dent.Full	0.00	0.00	0.00	0.00	0.19	1.30	4.34	7.25	4.90	4.61	1.27%
Dent.Part	0.39	0.00	0.00	0.10	1.94	3.22	10.42	12.46	9.53	7.31	2.83%
Den.Maint	0.00	0.00	0.00	0.02	0.21	0.77	3.06	4.26	3.99	9.02	1.03%
Extr.smpl	0.55	3.30	3.68	1.16	2.73	2.09	4.37	6.42	4.69	6.50	2.22%
Extr.imp	0.00	0.00	0.17	0.76	1.74	0.26	0.38	0.00	0.00	0.00	0.42%
Surg.Oth.	0.00	0.04	0.06	0.10	0.21	0.10	0.29	0.21	0.55	0.32	0.13%
Ortho	0.20	0.69	3.57	2.22	0.51	0.35	0.12	0.12	0.13	0.00	0.48%
Other	1.08	0.69	0.99	1.41	1.88	1.88	2.78	2.22	1.76	2.94	1.20% 21.2%
TOTAL	64.4	84.4	101.2	103.1	157.8	159.6	214.0	223.4	152.4	127.7	100.0%
POP(,000)											
24,484	733	1796	1789	1938	6928	3661	2561	2351	1666	1062	
HRS(,000)											
61,997	787	2527	3018	3331	18222	9736	9132	8751	4232	2260	

TIME REQUIREMENTS IN 2006 USING BASE 1986 FREQUENCIES (High Care Patient) Table 2

PROCEDURE	PROCEDURE TIME (min./patient)										TIME % DISTRIB
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+	
Comp.Exm	0.79	0.22	0.10	0.10	0.53	0.43	0.26	0.26	0.00	0.00	0.18%
Recl.Exm	12.72	14.20	16.00	13.87	15.83	15.96	17.06	17.83	13.57	13.44	9.87%
Other Exm	1.07	0.83	0.95	0.90	2.00	1.88	2.59	3.61	2.28	2.41	1.32%
Radg. 1	0.21	0.23	0.23	0.33	0.56	0.62	0.91	0.74	0.48	0.43	0.36%
Radg. 2	0.91	2.07	2.57	2.34	2.25	2.06	1.63	1.53	0.77	0.91	1.14%
Radg.Oth.	0.11	0.14	0.31	0.52	0.90	0.74	0.90	0.61	0.51	0.40	0.41%
Diag.Oth.	0.00	0.36	0.77	0.34	0.60	0.81	0.88	0.96	0.42	0.60	0.42% 13.7%
Prophy	15.57	20.70	25.76	22.37	28.51	27.70	32.31	32.92	24.43	23.85	17.35%
Fluor/Rem	5.52	7.10	8.20	5.21	2.63	2.03	2.26	1.99	1.39	1.30	1.93%
OHI	0.35	0.26	0.39	0.24	0.33	0.39	0.39	0.57	0.09	0.06	0.21%
Sealants	0.34	1.40	1.56	0.66	0.25	0.06	0.02	0.00	0.00	0.00	0.19%
Prev.Oth.	0.55	2.91	1.90	0.40	0.71	0.72	1.03	0.93	0.26	0.32	0.57% 20.3%
Amalgam	19.14	25.24	26.14	33.0	42.5	35.3	43.1	34.60	22.97	20.33	21.57%
Composite	3.14	1.90	4.69	8.23	17.40	18.29	24.59	31.75	22.00	17.85	11.43%
Crowns	0.83	0.61	0.26	1.32	8.80	12.83	18.45	20.96	8.45	3.26	6.50%
Bridges	0.00	0.00	0.06	0.72	2.65	4.87	6.01	7.57	6.16	0.15	2.34%
Rest.Oth.	0.00	0.13	0.30	1.00	2.14	2.81	2.98	5.03	4.22	0.83	1.54% 43.4%
Pulp Cap	0.03	0.01	0.02	0.02	0.08	0.08	0.05	0.02	0.02	0.02	0.03%
Cons.RCT	0.00	0.09	1.42	2.88	7.56	8.03	13.00	9.77	6.20	1.23	4.35%
Pulpotomy	0.95	0.99	0.14	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.06%
Endo Oth.	0.00	0.18	0.15	0.13	0.48	0.35	0.64	0.46	0.49	0.23	0.25%
Perio S&P	0.00	0.13	0.63	1.62	9.39	11.87	16.32	15.80	10.49	9.17	6.23%
Perio Oth	0.00	0.02	0.06	0.10	0.40	0.67	0.54	1.08	0.41	0.27	0.29%
Perio Surg.	0.00	0.00	0.00	0.02	0.42	0.37	1.10	0.43	0.63	0.00	0.26%
TMJ	0.00	0.00	0.17	1.05	1.48	0.73	1.13	1.00	0.61	0.00	0.53%
Dent.Full	0.00	0.00	0.00	0.00	0.19	1.30	4.34	7.25	4.90	4.61	1.58%
Dent.Part	0.39	0.00	0.00	0.10	1.94	3.22	10.42	12.46	9.53	7.31	3.36%
Den.Maint	0.00	0.00	0.00	0.02	0.21	0.77	3.06	4.26	3.99	9.02	1.33%
Extr.smpl	0.55	3.30	3.68	1.16	2.73	2.09	4.37	6.42	4.69	6.50	2.33%
Extr.imp	0.00	0.00	0.17	0.76	1.74	0.26	0.38	0.00	0.00	0.00	0.33%
Surg.Oth.	0.00	0.04	0.06	0.10	0.21	0.10	0.29	0.21	0.55	0.32	0.13%
Ortho	0.20	0.69	3.57	2.22	0.51	0.35	0.12	0.12	0.13	0.00	0.39%
Other	1.08	0.69	0.99	1.41	1.88	1.88	2.78	2.22	1.76	2.94	1.23% 22.7%
TOTAL	64.4	84.4	101.2	103.1	157.8	159.6	214.0	223.4	152.4	127.7	100.0%
POP(,000)											
28,145	639	1655	1798	1913	5715	4393	4464	3428	2180	1961	
HRS(,000)											
74,445	686	2329	3033	3288	15033	11683	15918	12763	5538	4175	

OPTION 1 (High Care Patient) - TIME REQUIREMENTS IN 2006 Table 3

PROCEDURE	PROCEDURE TIME (min./patient)										TIME % DISTRIB
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+	
Comp.Exm	0.79	0.22	0.10	0.10	0.54	0.44	0.27	0.27	0.00	0.00	0.22%
Recl.Exm	12.72	14.20	16.00	16.80	16.80	16.80	16.80	16.80	16.80	16.80	12.12%
Other Exm	1.07	0.83	1.13	1.08	2.00	1.88	3.11	4.33	2.74	2.50	1.71%
Radg. 1	0.17	0.19	0.18	0.26	0.45	0.49	0.73	0.59	0.38	0.34	0.33%
Radg. 2	0.73	1.66	1.95	1.95	1.95	1.95	0.78	0.39	0.39	0.39	0.96%
Radg.Oth.	0.11	0.14	0.44	0.63	0.90	0.74	1.08	0.73	0.51	0.40	0.52%
Diag.Oth.	0.00	0.36	0.77	0.34	0.34	0.38	0.36	0.50	0.42	0.60	0.30% 16.2%
Prophy	16.27	19.95	24.66	28.07	28.20	28.35	28.35	28.35	28.35	28.35	20.05%
Fluor/Rem	6.44	7.19	8.10	8.51	5.67	2.84	2.26	1.99	1.39	1.30	2.98%
OHI	0.38	0.28	0.43	0.26	0.36	0.43	0.43	0.63	0.10	0.07	0.27%
Sealants	0.36	3.98	3.76	0.94	0.25	0.06	0.02	0.00	0.00	0.00	0.45%
Prev.Oth.	0.55	2.91	1.90	0.40	0.35	0.54	0.77	0.84	0.26	0.32	0.55% 24.3%
Amalgam	19.14	18.93	19.60	24.8	21.2	8.8	10.8	34.60	22.97	20.33	14.18%
Composite	3.14	1.90	4.69	6.59	9.24	13.72	18.44	23.81	24.20	13.39	9.98%
Crowns	0.83	0.61	0.26	1.32	6.16	10.26	16.60	22.00	10.14	3.26	6.86%
Bridges	0.00	0.00	0.06	0.36	0.74	2.43	4.21	3.78	1.85	0.15	1.35%
Rest.Oth.	0.00	0.13	0.30	0.60	1.29	1.69	2.09	5.03	4.22	0.83	1.41% 33.8%
Pulp Cap	0.03	0.01	0.02	0.02	0.04	0.06	0.05	0.02	0.02	0.02	0.03%
Cons.RCT	0.00	0.09	1.42	2.88	3.78	4.02	10.40	9.77	6.20	1.23	3.74%
Pulpotomy	0.95	0.99	0.14	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.07%
Endo Oth.	0.00	0.18	0.15	0.13	0.48	0.35	0.64	0.46	0.49	0.23	0.29%
Perio S&P	0.00	0.13	0.63	1.62	15.00	15.00	21.00	21.00	16.50	16.50	10.18%
Perio Oth	0.00	0.02	0.06	0.10	0.40	0.74	0.60	1.19	0.45	0.30	0.37%
Perio Surg.	0.00	0.00	0.00	0.02	0.42	0.37	1.10	0.43	0.63	0.00	0.31%
TMJ	0.00	0.00	0.17	1.05	1.48	0.73	1.13	1.00	0.61	0.00	0.62%
Dent.Full	0.00	0.00	0.00	0.00	0.19	0.65	2.17	4.35	4.90	4.61	1.26%
Dent.Part	0.39	0.00	0.00	0.10	0.66	1.61	7.29	8.72	8.77	6.72	2.77%
Den.Maint	0.00	0.00	0.00	0.02	0.07	0.38	1.98	2.87	3.75	8.45	1.19%
Extr.smpl	0.55	3.30	3.68	1.16	1.64	1.05	2.18	3.21	2.35	3.25	1.59%
Extr.imp	0.00	0.00	0.17	0.76	1.74	0.26	0.38	0.00	0.00	0.00	0.38%
Surg.Oth.	0.00	0.04	0.06	0.10	0.21	0.10	0.29	0.21	0.55	0.32	0.15%
Ortho	0.20	2.76	14.28	8.88	0.51	0.35	0.12	0.12	0.13	0.00	1.38%
Other	1.08	0.69	0.99	1.41	1.88	1.88	2.78	2.22	1.76	2.94	1.43% 25.8%
TOTAL	65.9	81.7	106.1	111.2	125.0	119.4	159.2	200.2	161.8	133.6	100.0%
POP(,000)											
28,145	639	1655	1798	1913	5715	4393	4464	3428	2180	1961	
HRS(,000)											
63,854	701	2253	3178	3545	11907	8738	11843	11441	5881	4366	

OPTIION 2 (High Care Patient) - TIME REQUIREMENTS IN 2006 Table 4

PROCEDURE	PROCEDURE TIME (min./patient)										TIME % DISTRIB
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+	
Comp.Exm	0.79	0.22	0.10	0.10	0.54	0.44	0.27	0.27	0.00	0.00	0.22%
Rec1.Exm	12.72	14.20	16.00	16.80	16.80	16.80	16.80	16.80	16.80	16.80	12.20%
Other Exm	1.07	0.83	1.13	1.08	2.00	1.88	3.11	4.33	2.74	2.50	1.72%
Radg. 1	0.17	0.19	0.18	0.26	0.45	0.49	0.73	0.59	0.38	0.34	0.34%
Radg. 2	0.73	1.66	1.95	1.95	1.95	1.95	0.78	0.39	0.39	0.39	0.96%
Radg.Oth.	0.11	0.14	0.44	0.63	0.90	0.74	1.08	0.73	0.51	0.40	0.52%
Diag.Oth.	0.00	0.36	0.77	0.34	0.34	0.38	0.36	0.50	0.42	0.60	0.31% 16.3%
Prophy	16.27	19.95	24.66	28.07	28.20	28.35	28.35	28.35	28.35	28.35	20.18%
Fluor/Rem	6.44	7.19	8.10	8.51	5.67	2.84	2.26	1.99	1.39	1.30	3.00%
OHI	0.38	0.28	0.43	0.26	0.36	0.43	0.43	0.63	0.10	0.07	0.27%
Sealants	0.36	3.98	3.76	0.94	0.25	0.06	0.02	0.00	0.00	0.00	0.45%
Prev.Oth.	0.55	2.91	1.90	0.40	0.35	0.54	0.77	0.84	0.26	0.32	0.56% 24.5%
Amalgam	16.27	16.09	16.66	21.0	21.2	8.8	10.8	34.60	22.97	20.33	13.77%
Composite	2.67	1.61	3.99	5.93	9.24	13.72	18.44	23.81	24.20	13.39	9.96%
Crowns	0.71	0.52	0.26	1.32	6.16	10.26	16.60	22.00	10.14	3.26	6.90%
Bridges	0.00	0.00	0.06	0.36	0.74	2.43	4.21	3.78	1.85	0.15	1.36%
Rest.Oth.	0.00	0.13	0.30	0.60	1.29	1.69	2.09	5.03	4.22	0.83	1.42% 33.4%
Pulp Cap	0.03	0.01	0.02	0.02	0.04	0.06	0.05	0.02	0.02	0.02	0.03%
Cons.RCT	0.00	0.09	1.42	2.88	3.78	4.02	10.40	9.77	6.20	1.23	3.76%
Pulpotomy	0.71	0.74	0.14	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.05%
Endo Oth.	0.00	0.18	0.15	0.13	0.48	0.35	0.64	0.46	0.49	0.23	0.29%
Perio S&P	0.00	0.13	0.63	1.62	15.00	15.00	21.00	21.00	16.50	16.50	10.25%
Perio Oth	0.00	0.02	0.06	0.10	0.40	0.74	0.60	1.19	0.45	0.30	0.37%
Perio Surg.	0.00	0.00	0.00	0.02	0.42	0.37	1.10	0.43	0.63	0.00	0.31%
TMJ	0.00	0.00	0.17	1.05	1.48	0.73	1.13	1.00	0.61	0.00	0.62%
Dent.Full	0.00	0.00	0.00	0.00	0.19	0.65	2.17	4.35	4.90	4.61	1.27%
Dent.Part	0.39	0.00	0.00	0.10	0.66	1.61	7.29	8.72	8.77	6.72	2.79%
Den.Maint	0.00	0.00	0.00	0.02	0.07	0.38	1.98	2.87	3.75	8.45	1.20%
Extr.smpl	0.27	2.80	3.13	1.16	1.64	1.05	2.18	3.21	2.35	3.25	1.55%
Extr.imp	0.00	0.00	0.17	0.76	1.74	0.26	0.38	0.00	0.00	0.00	0.38%
Surg.Oth.	0.00	0.04	0.06	0.10	0.21	0.10	0.29	0.21	0.55	0.32	0.15%
Ortho	0.20	2.76	14.28	8.88	0.51	0.35	0.12	0.12	0.13	0.00	1.39%
Other	1.08	0.69	0.99	1.41	1.88	1.88	2.78	2.22	1.76	2.94	1.44% 25.9%
TOTAL	61.9	77.7	101.9	106.8	125.0	119.4	159.2	200.2	161.8	133.6	100.0%
POP(,000)											
28,145	639	1655	1798	1913	5715	4393	4464	3428	2180	1961	
HRS(,000)											
63,437	659	2144	3053	3406	11907	8738	11843	11441	5881	4366	

PERCENT DIFF. OPTION 2 AND BASE (High Care Patient)

Table 5

PROCEDURE	PROCEDURE FREQUENCIES (per Patient)									
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+
Comp.Exm	0.00%	0.00%	0.00%	0.00%	2.00%	2.00%	2.00%	4.00%	0.00%	0.00%
Recl.Exm	0.00%	0.00%	0.00%	21.11%	6.14%	5.26%	-1.55%	-5.79%	23.78%	25.00%
Other Exm	0.00%	0.00%	20.00%	20.00%	0.00%	0.00%	20.00%	20.00%	20.00%	4.00%
Radg. 1	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%	-20.00%
Radg. 2	-20.00%	-20.00%	-24.13%	-16.53%	-13.19%	-5.48%	-52.15%	-74.49%	-49.24%	-57.26%
Radg.Oth.	0.00%	0.00%	40.00%	20.00%	0.00%	0.00%	20.00%	20.00%	0.00%	0.00%
Diag.Oth.	0.00%	0.00%	0.00%	0.00%	-42.86%	-53.49%	-59.18%	-47.92%	0.00%	0.00%
Prophy	4.49%	-3.65%	-4.25%	25.50%	-1.10%	2.36%	-12.26%	-13.88%	16.02%	18.87%
Fluor/Rem	16.66%	1.29%	-1.21%	63.17%	115.38%	40.00%	0.00%	0.00%	0.00%	0.00%
OHI	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%
Sealants	6.00%	183.69%	140.96%	42.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Prev.Oth.	0.00%	0.00%	0.00%	0.00%	-50.00%	-25.00%	-25.00%	-10.00%	0.00%	0.00%
Amalgam	-15.00%	-36.25%	-36.25%	-36.25%	-50.00%	-75.00%	-75.00%	0.00%	0.00%	0.00%
Composite	-15.00%	-15.00%	-15.00%	-28.00%	-46.90%	-25.00%	-25.00%	-25.00%	10.00%	-25.00%
Crowns	-15.00%	-15.00%	0.00%	0.00%	-30.00%	-20.00%	-10.00%	5.00%	20.00%	0.00%
Bridges	0.00%	0.00%	0.00%	-50.00%	-72.00%	-50.00%	-30.00%	-50.00%	-70.00%	0.00%
Rest.Oth.	0.00%	0.00%	0.00%	-40.00%	-40.00%	-40.00%	-30.00%	0.00%	0.00%	0.00%
Pulp Cap	0.00%	0.00%	0.00%	0.00%	-50.00%	-22.00%	0.00%	0.00%	0.00%	0.00%
Cons.RCT	0.00%	0.00%	0.00%	0.00%	-50.00%	-50.00%	-20.00%	0.00%	0.00%	0.00%
Pulpotomy	-25.00%	-25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Endo Oth.	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Perio S&P	0.00%	0.00%	0.00%	0.00%	59.74%	26.42%	28.68%	32.95%	57.37%	80.03%
Perio Oth	0.00%	0.00%	0.00%	0.00%	0.00%	10.00%	10.00%	10.00%	10.00%	10.00%
Perio Surg.	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TMJ	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Dent.Full	0.00%	0.00%	0.00%	0.00%	0.00%	-50.00%	-50.00%	-40.00%	0.00%	0.00%
Dent.Part	0.00%	0.00%	0.00%	0.00%	-66.00%	-50.00%	-30.00%	-30.00%	-8.00%	-8.00%
Den.Maint	0.00%	0.00%	0.00%	0.00%	-66.00%	-50.00%	-35.43%	-32.74%	-6.00%	-6.31%
Extr.smpl	-50.00%	-15.00%	-15.00%	0.00%	-40.00%	-50.00%	-50.00%	-50.00%	-50.00%	-50.00%
Extr.imp	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Surg.Oth.	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ortho	0.00%	300.00%	300.00%	300.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

OPTION 3 (High Care Patient) - TIME REQUIREMENTS IN 2006 Table 6

PROCEDURE	PROCEDURE TIME (min./patient)										TIME % DISTRIB
	3-4	5-9	10-14	15-19	20-34	35-44	45-54	55-64	65-74	75+	
Comp.Exm	0.79	0.22	0.10	0.10	2.31	2.31	2.32	2.32	2.31	0.26	1.27%
Recl.Exm	12.72	14.20	16.00	16.81	16.80	16.81	16.89	16.85	16.83	16.80	12.16%
Other Exm	1.07	0.83	1.13	1.08	2.00	1.88	3.11	4.33	2.74	2.50	1.71%
Radg. 1	0.17	0.19	0.18	0.26	0.45	0.49	0.73	0.59	0.38	0.34	0.33%
Radg. 2	0.73	1.66	1.95	1.95	1.95	1.95	0.78	0.39	0.39	0.39	0.96%
Radg.Oth.	0.11	0.14	0.44	0.63	0.90	0.74	1.08	0.73	0.51	0.40	0.52%
Diag.Oth.	0.00	0.36	0.77	0.34	0.34	0.38	0.36	0.50	0.42	0.60	0.30% 17.3%
Prophy	16.27	19.95	24.66	28.09	28.20	28.36	28.51	28.44	28.40	28.35	20.11%
Fluor/Rem	6.44	7.19	8.10	8.51	5.67	3.00	3.00	2.94	2.05	1.92	3.24%
OHI	0.38	0.28	0.43	0.26	0.36	0.43	0.43	0.63	0.45	0.30	0.30%
Sealants	0.36	3.98	3.76	0.95	0.25	0.06	0.02	0.00	0.00	0.00	0.45%
Prev.Oth.	0.55	2.91	1.90	0.40	0.35	0.55	0.77	0.83	0.26	0.32	0.55% 24.7%
Amalgam	16.27	16.09	16.66	21.0	21.2	8.8	10.8	34.60	22.97	20.33	13.70%
Composite	2.67	1.61	3.99	5.93	10.11	14.63	19.67	23.81	24.20	13.39	10.28%
Crowns	0.71	0.52	0.26	1.32	6.16	10.26	16.60	22.00	10.14	3.26	6.86%
Bridges	0.00	0.00	0.06	0.36	0.74	2.43	4.21	3.78	1.85	0.15	1.35%
Rest.Oth.	0.00	0.13	0.30	0.60	1.29	1.69	2.09	5.03	4.22	0.83	1.41% 33.6%
Pulp Cap	0.03	0.01	0.02	0.02	0.04	0.06	0.05	0.02	0.02	0.04	0.03%
Cons.RCT	0.00	0.09	1.42	2.88	3.78	4.02	10.40	9.77	6.20	1.23	3.74%
Pulpotomy	0.71	0.74	0.14	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.05%
Endo Oth.	0.00	0.18	0.15	0.13	0.48	0.35	0.64	0.07	0.49	0.23	0.25%
Perio S&P	0.00	0.13	0.63	1.62	12.00	12.00	18.90	18.91	16.50	16.50	8.97%
Perio Oth	0.00	0.02	0.13	0.14	0.28	0.76	0.63	0.92	0.56	0.36	0.35%
Perio Surg.	0.00	0.00	0.00	0.02	0.42	0.37	1.10	0.43	0.63	0.00	0.31%
TMJ	0.00	0.00	0.00	1.19	1.62	0.79	1.85	1.85	1.17	0.00	0.84%
Dent.Full	0.00	0.00	0.00	0.00	0.19	0.65	2.17	4.35	4.90	4.61	1.26%
Dent.Part	0.39	0.00	0.00	0.10	0.66	1.61	7.29	8.72	8.77	6.68	2.77%
Den.Maint	0.00	0.00	0.00	0.02	0.07	0.36	1.98	2.87	3.75	5.91	1.06%
Extr.smpl	0.27	2.80	3.13	1.16	1.64	1.05	2.18	3.21	2.35	3.25	1.54%
Extr.imp	0.00	0.00	0.17	0.76	1.74	0.26	0.38	0.00	0.00	0.00	0.38%
Surg.Oth.	0.00	0.04	0.06	0.10	0.21	0.10	0.29	0.21	0.55	0.32	0.15%
Ortho	0.20	2.76	14.28	8.88	0.51	0.35	0.12	0.12	0.13	0.00	1.39%
Other	1.08	0.69	0.99	1.31	1.74	1.88	2.78	2.36	1.76	2.45	1.39% 24.5%
TOTAL	61.9	77.7	101.8	107.0	124.5	119.4	162.1	201.6	165.9	131.7	100.0%
POP(,000)	28,145	639	1655	1798	1913	5715	4393	4464	3428	2180	1961
HRS(,000)	63,778	659	2144	3050	3409	11864	8740	12061	11518	6029	4305



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

October 1, 1986

Mr. J.C. Lovelace, Assistant Deputy Minister
Management Operations, Ministry of Health
1515, Blanshard Street
VICTORIA (B.C.)
V8W 3C8

Dear Mr. Lovelace:

It has been one year now since the Canadian Dental Association became seized of a human resource problem facing the profession. It is my understanding that the Federal Provincial Advisory Committee on Health Human Resources has also been working in a similar vein with regard to human resources of the health field in general.

Over the past year, the Canadian Dental Association has sponsored a Manpower Symposium, a conference on prelicensure, and has struck a committee to examine the human resource question. The Committee's work has progressed to the point where it could very well be in our mutual interest to meet, for two principal purposes:

- 1) To explain the genesis of CDA's "Manpower" problem, how CDA perceives the current situation, and how it expects its coming thrusts will focus; and,
- 2) To make itself aware of the work of the Federal Provincial Advisory Committee on this issue.

All of the above, of course, would be in the context of avoiding duplication of effort, and the sharing of information and results.

If you feel that such a meeting would be appropriate, CDA would be pleased to name a representative to attend a coming meeting of your Committee. I look forward to hearing from you in this regard.

Sincerely yours,


A. Jardine Neilson

Executive Director

c.c. Dr. Bradley W. Holmes, Past-President
/ml

MEMORANDUM

January 15, 1987

TO: Chairman and Members - Board of Governors
 Presidents and CEO's - Corporate Members
 Presidents and CEO's - Licensing Bodies
 Deans - Canadian Dental Faculties

FROM: A. Jardine Neilson, Executive Director

SUBJECT: PROFESSIONAL RESOURCE UTILIZATION

As you are aware, from the report of the Professional Resource Utilization Committee to the 1986 Annual Meeting of the CDA Board of Governors, Dental Manpower Studies conducted by R.K. House and Associates in 1982 and 1984 have been re-examined, updated and their conclusions re-affirmed. The CDA sponsored a workshop during the Summer of 1986, which produced a report on the demand for dental care through to the year 2006 (to be published in the February, 1987 edition of the CDA Journal under the title "Estimating Future Dental Care Requirements: The Implications for Dental Manpower"). A copy of this report is enclosed for your information.

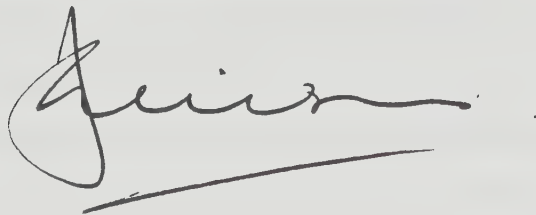
In response to an invitation from Dr. Holmes, Chairman of the Professional Resource Utilization Committee (PRUC), the Deans of all Canadian dental faculties, and the Presidents of the ACFD and the CDHA met with the PRUC for presentation and consideration of the supply/demand data, discussion of the implications for the public and the profession, and formulation of actions necessary to reach an appropriate resolution.

Attached for your information is a copy of an article which will appear in the January Communiqué, which highlights the agreement reached at that meeting, and proposes future action.

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The anticipated recommendation on enrolment cutbacks impacts on all provincial government authorities. The Canadian Dental Association requests your support in sensitizing and influencing government authorities within your jurisdictions to the difficult decisions that must be taken with regard to enrolment, if the very real problem of oversupply is to be resolved.

A handwritten signature in dark ink, appearing to read "Fein", with a long horizontal line underneath it.

/ml

Encls.

CDA ACTS ON DENTAL MANPOWER

In the fall of 1985, the CDA sponsored a National Manpower Symposium, the conclusion of which saw your national association mandated to review and take action with regard to dental professional resource utilization. The CDA Professional Resource Utilization Committee (PRUC) was then established to study the present and future resource situation, and to present recommendations to the CDA Board of Governors. Under the chairmanship of Dr. Bradley Holmes, membership on the PRUC includes representation from the lay public, the CDA membership at large, the Association of Canadian Faculties of Dentistry, the Canadian Dental Hygienists' Association, and Health and Welfare Canada.

Major activities of the Committee during 1986 involved re-examination and re-affirmation of the conclusions of the Dental Manpower Studies conducted by R.K. House and Associates for the CDA in 1982 and 1984, and the sponsoring of a study on the demand for dental care through to the year 2006. These supply and demand figures project a future over-supply of dental professional resources, if action is not taken to adjust current supply norms.

To facilitate the next stage of the Committee's work, one of consultation and communication, a meeting with the Deans of all Canadian dental faculties, the ACFD, and the CDHA was held in Montreal on January 10, 1987. The general consensus reached was that a very real dental professional

.../2

resource problem exists in Canada today. Unanimous agreement was reached by the deans of all Canadian dental faculties that a substantial reduction in the professional output of dental schools is required. The CDA will sponsor a follow-up meeting of the deans, which will focus on the delineation of an action plan for reduction in enrolment for the 1988-89 academic year.

The CDA has accepted the responsibility for communicating all critical information surrounding these decisions to the political level. As well, a summary of the supply/demand report will be sent to the Federal/Provincial Committee on Health Human Resources, to facilitate communication with provincial ministers of health and the federal government.

The CDA is cognizant of its responsibility in this area and will continue to work through the PRUC to facilitate the search for solutions. The Committee plans to present a full report with recommendations to the Interim Meeting of the CDA Board of Governors in April, 1987.

Look for published reports on "Estimating Future Dental Care Requirements: The Implications for Dental Manpower", and a report on supply/demand forecasts, in the February and March issues of the CDA Journal.

1987-01-14

/ml

AN EXECUTIVE SUMMARY
OF THE CANADIAN DENTAL MANPOWER PROBLEM

It has taken several years for C.D.A. sponsored research into dental manpower to complete the development of a sophisticated manpower simulation model, and to complete the development of a comprehensive statistical data base. Many interested parties have studied and investigated both the data and the methodology; these parties include government officials, the lay public, academics from most of the Canadian dental schools, representatives of dental associations, and dentists in private practice. The research program has withstood this scrutiny and has, in fact, benefitted from the many valuable contributions that have been made to the development of this model. The conclusion that there will be far too many dentists in the future has never been in doubt.

In spite of the complex and comprehensive research effort, the conclusion that there will be excessive number of dentists is easily established from just a few numbers and from a simple and direct chain of logic.

Between 1986 and 2006 the Canadian population is expected to grow by 13%. The "academic consensus", which resulted from C.D.A.'s 1986 "Demand Side Conference" is that - in terms of treatment time required - dental disease will decline by 10% from 113.5 minutes per patient per year in 1986 to about 102 minutes in 2006. Moreover, the expectation is that, because of a change in the

mix of procedures, the required "dentist's time" per patient will fall between 13.6% and 17.3% while auxiliary time will increase between 8.0% and 10.5%. From this it seems clear that the 13.0% increase in the population will be effectively offset by the decline in dental disease. In our view there can be no serious dispute of any significant magnitude with respect to either the population growth or the evidence documenting the decline in dental disease.

Comparing total demand between the years 1986 and 2006 suggests that the total time required to treat patients will increase between 2.8% and 5.3%. The requirement for dentists' time (as opposed to auxiliaries' time) will decrease, falling by as much as 4.9%. It is on this basis that we can make the dramatic statement that a net increase in the number of dentists over the next twenty years is not needed.

This essentially static demand contrasts sharply with what is expected to happen in terms of the "supply" of dentists. The number of dentists is projected to increase by 28.0%. The number of hygienists is projected to increase by 163% and the number of C.D.A.'s by 147%. The growth in supply will dramatically outstrip the growth in demand.

To maintain the same balance between supply and demand in 2006 as we have today would require reducing graduates from Canadian dental schools by

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approximately 55.0% after 1991. Recognizing that social and health care patterns do change over time, we feel that a reduction of this magnitude is excessive. Based on the information currently available, a reduction of 35.0% is the least that is needed.

AD HOC COMMITTEE ON PUBLICATIONS

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. Ron J. Markey, Chairman, Vancouver
 Dr. P. Ralph Crawford, Winnipeg
 Dr. Terry Koltek, Winnipeg
 Dr. John Hardie, Ottawa

Council Meeting

A first meeting of the Ad Hoc Committee on Publications was held in Winnipeg, December 5, 1986, and a second and final meeting was held on January 16, 1987, in Winnipeg also.

ITEMS REQUIRING BOARD ACTION

A review of the original minutes-report revealed consensus on the Committee's orientation and direction. Further discussion took place with regard to the utilization of an outside house for Journal publishing activities. This will continue to be explored, and if it offers financial management, and administrative advantages to CDA, the Executive Director will move in that direction. The Committee also reinforced its support for the ideas contained on page 3 of the December 5, 1986 minutes.

APPENDIX I

The Committee met with the Journal Editor, Ms. Carolyn Hackland, who presented her views on our original deliberations. It should be noted that Ms. Hackland also submitted a full report covering her assessment of the Journal situation prior to the original meeting of the Committee, which has been most useful. The meeting with Ms. Hackland indicated clearly that the thoughts of the Ad Hoc Committee were for the most part consistent with the views of the Editor, and her responses in most areas were positive and encouraging with regard to the future direction the Committee is promoting. The key areas of the original minutes were reviewed.

.../2

1. Editorial Board - Editorial Policy - Scientific Content

The Editor agrees with the Committee's proposals. She feels that the input from Scientific Editors should remain strong, and felt that the quality of the scientific articles were sound and that their numbers are on the increase. She supports an increased focus on clinical articles, and feels that increased use should be made of free-lance writers, in order to obtain well-researched articles on specific topical areas. She agrees that the Journal has no distinct editorial policy, and welcomes suggestions in this area, including the fact that the Journal should become more controversial and generally more pro-active, rather than reactive on national health and safety issues.

A number of suggestions were put forward that will be pursued regarding issues such as content and article mix. She strongly recommends a higher profile for the Journal at cross-country meetings and functions. It is felt that this visibility is paramount to increase the Journal coverage and profile nationally. The Committee agrees and recommends that this be a future budget consideration. As well, the recommendation of a Publications Committee was endorsed by the Editor.

2. Urgent Issues

The recommendation that inserts be utilized by the Journal was endorsed, with the caution that cost factors be fully explored.

3. CDA News

There was general agreement on the original comments in this area. Specific suggestions were put forward by the Editor to the effect that coverage should be increased in several areas including:

- (a) Dental Industry News;
- (b) Focus Features on Specific Councils or Committees;
- (c) Short Topical News Stories of National Interest;
- (d) A Convention Column;
- (e) Indepth Analysis of Current Topical Issues; and,
- (f) Publishers Page (for example, CDA Political Comments).

AD HOC COMMITTEE ON PUBLICATIONS

4. Interviews

This concept was enthusiastically endorsed by all. Specific mention was made of an Annual Interview with the incoming President. (This suggestion was not made by the incoming President!).

5. Esthetics

It was agreed that moves on this aspect of the Journal are essential.

There was general agreement in all other areas, including advertising, timing of changes, and management of the Journal. It was reiterated that the Journal cannot be run by a committee. The Editor must be responsible for carrying out day to day operations, and stand to account for the results.

It is expected that the structural changes being recommended will result in a period of anxiety and uncertainty as is the case with the introduction of change to any system. It is expected however, that with the "will to succeed", this will resolve itself in the short run.

The future direction of Communications is one of the most important issues facing CDA today. We must be willing to change, in the hope that we can do better, or stagnation will occur in specific areas which, in the short run will hurt our credibility, and, in the long run cost us support and membership. The Committee feels that the directions taken in the government relations and public information areas is, generally speaking, on track. Professional communications, however, need refurbishing. If the recommendation is accepted by the Executive Council and agreed to by the Board of Governors, two potential areas of overlap and role confusion should be clarified at this time.

1. There is bound to be a degree of overlap between the proposed terms of reference of the Publications Committee (enclosed herein), and the Council on Information Services. Although it is expected that specific CDA publications will receive most attention, the mandate of the Publications Committee will include a periodic review of CDA Communications instruments such as newsletters, pamphlets, brochures, and fact sheets. This is in the interest of rationalization, cost efficiency and philosophical congruence. It is not intended that a Council such as Information Services be subservient to seek permission from the Publications Committee in its relationship to Executive Council with regard to its recommendation for printed material, including pamphlets and fact sheets. It has its own

AD HOC COMMITTEE ON PUBLICATIONS

mandate and budget, and it is not in the best interests of CDA to increase the number of screens that a Council or Committee must traverse in order to get action. The Council on Information Services deals more directly with educational material, and there is no intent here to override or complicate its mandate for this sphere of activity.

2. From time to time, the Council on Student Affairs produces publications. These should be reviewed by the Publications Committee. Specific emphasis is placed here on the Practice Management Manual. It has been suggested that, in future, it might be made available to the general membership. This has the potential to become a quality membership service, and could also help to defray the high cost of the publication. The Committee is also confident that the new internal structure at the CDA will afford the Director of Communications the opportunity to coordinate and supervise all of these areas, referring to Publications Committee as needed, on a regularly-scheduled basis.

The Ad Hoc Committee on Publications makes the following recommendations to Executive Council and the Board of Governors:

RESOLVED:

87.16 THAT the Editorial Board be disbanded.

ADOPTED

RESOLVED:

87.17 THAT a Publications Committee be formed as a standing committee of the Executive Council.

ADOPTED

RESOLVED:

87.18 THAT the following terms of reference for the Publications Committee be accepted:

Terms of Reference:

1. The Committee shall be a standing committee of the Executive Council and represent the general CDA membership in ensuring that CDA publications are effective and pertinent.

AD HOC COMMITTEE ON PUBLICATIONS

2. The Committee shall consist of a chairperson, two members-at-large and the Executive Director. The Director of Communications is the principal staff officer to the Committee and will be assisted in this role by the Journal Editor and the Information Officer as required.
3. The Chairperson and members at large shall be selected by Executive Council to serve a term of office of three (3) years, renewable once. Appointments shall be made in a staggered manner.
4. The Committee shall meet up to four times per year, and shall report directly to the Executive Council.
5. The Committee shall make recommendations with regard to the fiscal, editorial, advertising, and content policy of relevant CDA publications.

ADOPTED

RESOLVED:

87.19 THAT the following individuals be approached to be part of the initial Publications Committee of CDA, for the terms of office indicated:

- Chairman: Dr. John Hardie
(Year 1, Term 1)
- Members at large: Dr. Ralph Crawford
(Year 2, Term 1)

Dr. Pierre Desautels
(Year 3, Term 1)

ADOPTED

RESOLVED:

87.20 THAT the Ad Hoc Committee on Publications be disbanded, with all future activity and recommendations in this area to come through the newly-constituted Publications Committee.

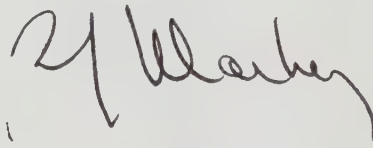
ADOPTED

AD HOC COMMITTEE ON PUBLICATIONS

- 6 -

Personal thanks are extended to all members of Committee and the Journal Editor for their enthusiastic participation and input.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "Ron J. Markey", written in a cursive style.

Ron J. Markey, Chairman
Ad Hoc Committee on Publications

ADOPTION OF REPORT

The Board of Governors accepts the report of the Ad Hoc Committee on Publications with appreciation.

MINUTES OF THE
AD HOC COMMITTEE ON PUBLICATIONS MEETING
HELD IN WINNIPEG - DECEMBER 5, 1986

Members: Ron J. Markey, Chairman
 Dr. Ralph Crawford
 Dr. Terry Koltek
 Dr. John Hardie

 Mr. Jardine Neilson

Absent: Ms. Linda Teteruck

I. INTRODUCTION

The Committee held its first meeting in Winnipeg, Friday, December 5th, 1986. Its principal objective was to make a start towards fulfilling the mandate of the Executive Council motion to review CDA's communication policy in its broadest sense and, where reasonable, focus on specific suggestions that might improve the overall communications process for CDA. It is hoped that the Committee's deliberations will result in more effective direction to the administrators of CDA within a rational communications policy framework.

II. TERMS OF REFERENCE

The following terms of reference were suggested for the Committee:

1. To fulfill the mandate of the Executive Council, and conduct a full review of CDA's communications policy.
2. To review the existing CDA communication structures as they have developed, and assess their impact on CDA communications.
3. To determine a policy for communication with the professional community, government and the public-at-large.
4. To determine the best direction for CDA communications, and develop an appropriate framework for the future.

.../2

III. THE CURRENT COMMUNICATION NETWORK

The current CDA communication network involves interplay among a number of individuals and in-house structures. Examples of this are:

1. Executive Director:
 - Corporate Bodies
 - Licensing Bodies
 - Government (Individuals and Agencies)
 - Management Committee
 - Executive Council
 - Board of Governors
2. Communications portfolio (as it is to be developed):
 - a) Journal
 - b) Media relations
 - c) Communiqué
 - d) Information Services
 - e) Conventions
3. Various spokespersons delegated by Management or Executive Council to be CDA in-house and public consultants on specific issues or areas of professional concern.
4. Government communications initiated by a variety of sources from the Executive Director through to responses to specific government-related issues.

In attempting to coordinate and analyse the communication network, it was concluded that the Committee's objective is to meet needs related to three (3) specific areas:

- (1) Government
- (2) Public
- (3) Profession

L. Government

CDA's government communications are currently focused on:

- a) On-going activity by CDA Executive Director.
- b) Government-related activity coordinated by individuals and Councils in the areas of awareness, taxation, and medical services.

- c) Direct information provided by CDA Information Officer to government agencies and departments regarding CDA's activities and concerns.

It is suggested that a biannual report, drafted by the Government Relations Committee highlighting CDA's activity, with emphasis on reporting government related activity, would be a useful adjunct.

2. Public

Public communication is currently dealt with by:

- a) The President or spokespersons responsible for different areas.
- b) "Awareness" and associated activities.
- c) General in-house media relations and Information Services activity.

3. Profession

CDA methods of communicating with the profession include:

- a) Direct communication - by presidential visits and communication at meetings by any delegated individual.
- b) Written communication - Journal - Communiqué - Bulletins - Special publications.

The Committee feels that CDA efforts in the areas of public and government communication are improving. Concentration on its Awareness campaign and Government contacts is taking CDA in the right direction. While improvements, modifications and additions need to be made, the direction is positive and indicates that advantage is being taken of the skills and resources that can be brought to bear in these areas. This leads to professional communication.

Professional communication by personal contact can be improved. Greater reliance on spokespersons other than the President could increase CDA's ability to bring more messages to more people, more easily and in a more cost-effective manner. This policy is currently being discussed at Management and Executive levels, and to a certain degree is being implemented more broadly than in the past. This should continue, as a means to raising the profile of CDA, through promoting the excellence and commitment of more people involved in CDA, on behalf of different corporate bodies.

IV. COMMUNICATION VEHICLES

Over and above CDA's personal communication with the profession is its principal source of communications - the written word. The Committee reviewed the different forms of written communication, including their history, and a recent submission received from the Journal Editor. The principal vehicle CDA has at its disposal is the Journal, which has been supplemented by other forms of written communication. There has been a perceived need for these other forms (dental forum, communiqué) as well as a feeling that they are better in terms of speed, format, readability for certain types of messages, compared to the Journal. The importance of these auxiliary communications has grown, and requests for others grow. An example is the recent Taxation Committee submission to Executive Council, requesting a special taxation letter on a regular basis.

The Journal is a competently produced product. However, it is among the least-mentioned as a reference for scientific articles, and is the object of criticism on an on-going basis for its content and format. CDA must therefore ask itself, if in meeting all demands, it is attempting to mix and match an unmarkettable product, and what can be done to change and improve the product.

The Committee debated this issue and concluded that what CDA needs and should have is a consistent, dependable, predictable, exciting journal that would meet most of CDA's communications needs.

The main conclusion, in reviewing the history of the Journal with regard to all the proposals, motions, submissions and changes, is that for all the apparent suggestions and changes, very little has actually happened to give the Journal a dynamic fresh look. The Committee feels that if CDA is to succeed this time, it must have the will to make it happen. The Committee feels that if CDA can produce the kind of Journal that people are anxious to receive and read, the use of additional media can be limited in number, and smaller in size, and utilized to deal with specific, priority issues.

Given the focus on the Journal as the principal communications vehicle of choice, the Committee debated a number of issues and suggestions, including the following:

1. Abolishment of the current Editorial Board

The Board would be replaced by a Publications Committee which would be a Committee of Executive Council, and oversee the entire area of CDA written communication. It would have a Chairman and two other members chosen for their expertise, supplemented by the Executive Director, making it a Committee of four (4). The Communications Director, Journal Editor and Information Officer would be called upon as professional resources to the Committee. Preliminary suggestions are that Drs. John Hardie and Ralph Crawford would be two of the three nominees to this Committee. Publications would remain under the management control of the Executive Director, within the administrative structure. The Publications Committee would be a recommending body. Implementation of policy adopted would be the responsibility of the Executive Director, through the Communications Directorate. Membership on the Publications Committee would be for two three-year terms. It is recommended that there be no official Executive Liaison.

2. Editorial Policy

The Journal Editor "runs" the Journal. The Editor is accountable to the Director of Communications who reports to the Executive Director.

It is the feeling of the Committee that there has been a lack of editorial policy consistency over the last eleven (11) years. The editorial policy should reflect the goals of CDA and the Publications Committee. It was agreed that editorials themselves should have a broader impact, be about issues of concern, and should be pertinent and succinct. Guest editorials should be encouraged. Controversial topics should be tackled. In short, editorials should be provocative on any topic related or relevant to dentistry.

With regard to overall content, the mix of academic, scientific, clinical, and short "hands-on"-type of articles must be found to generate readership interest. The focus must be on membership interest. It is necessary, however, for a national publication to meet its responsibility to the academic and scientific community; the education of the reader must remain an important goal.

3. Scientific Content

Scientific articles should be properly refereed and vetted through the Publications Committee. It is essential that more clinically-oriented articles be obtained, and a method for obtaining more of the hands-on type of clinical short tips that are useful and popular be developed. In short, a more aggressive solicitation of the type of articles readers want, is required.

4. Urgent Issues

It was felt that a type of "insert" format could be developed that would allow last minute up-to-date information on topical issues to be disseminated with minimum lead time. For example, whether on taxation, capitation or awareness, this could be a quick, reliable method of making the Journal more current, more desirable and more important. These special inserts could be short or long as required, and could be used regularly. They could also be inserted for members only, if this was felt to be a desirable membership benefit.

5. Interviews

Published interviews were thought to be a valuable, topical, and under-utilized technique item that the Journal should consider.

6. CDA News

The Committee agreed with a number of observations that this is important, but not if carried to excess. Council, Committee, Convention and other general news of interest should be relevant and of interest to the membership. It should not be so "in" as to be irrelevant to most readers.

7. Esthetics

The Committee felt that this was very important and one of the aspects that could improved quickly. A more esthetically-pleasing format and consistent cover were mentioned. The use of color is important, recognizing cost implications. The Journal needs to be refurbished and reformed into a more exciting package. In short, "jazz it up!"

8. Publication Policy

An alternate method of publishing is being examined; the Committee expects a more complete report from the Executive Director at the next Committee meeting in January. The objective would be to increase advertising revenue, and relieve the editorial staff of administrative management and business decisions, leaving it free to concentrate on the creative aspects of Journal production

9. Advertising

A number of comments were reviewed with respect to Journal advertising policy, including those submitted by the Editor. It was generally agreed that the advertising policy must be broadened. There are certain areas that must be avoided, such as tobacco, and liquor advertising, and the covenant on products that are directly competitive with CDSPI products must also be maintained. This still allows for a wide range of ideas that could expand the advertising base and increase Journal revenue. The Committee supports this concept. In the business sense, CDA attitudes in this area are unrealistic in today's market place.

10. Timing

Whatever suggestions ultimately form the basis of the final report will require several months to implement. Esthetic change can come quickly; the rest must follow a reasonable time-table established by joint consultation with the Publications Committee, the Director of Communications and the Journal Editor.

11. Next Meeting

The next meeting of the Ad Hoc Committee on Publications is scheduled for Friday, January 16, 1987, in Winnipeg. An update from the Executive Director is anticipated regarding publishing. The Committee will then meet with the Director of Communications and the Journal Editor. The Committee will continue to meet in the afternoon.

The enclosed is an attempted draft of some of the Committee's thoughts and positions. Much of what is included has been written and suggested before; there is not much original material. If CDA is to be different or more

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successful than others who have taken on parts of this task in the past, it will have to persevere and maintain its commitment to seeing CDA communications become a source of pride for the organization.

Respectfully submitted,

Ron J. Markey, D.D.S., M.S.D.
Chairman - Ad Hoc Committee on
Publications

/ml

1987-01-06

ROLES AND RESPONSIBILITIES COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. John Christie, Chairman
 Dr. Robert Hicks
 Dr. Jack Niedermayer
 Dr. Kevin Roach

1. Committee Meetings

Since the 1986 Annual Meeting of the Board of Governors, the Committee has met twice, on August 24, 1986 and January 30, 1987.

ITEMS REQUIRING BOARD ACTION

2. Committee on Dental Specialties

Areas of discussion pursued on this topic, in order to respond to items identified by specialty sections are outlined below:

- (i) Council vs Committee;
- (ii) Term of membership;
- (iii) Appointment of Chairman;
- (iv) CDA representation;
- (v) Role of the RCDC observer.

(i) Council vs Committee

Members agreed that the request for a Council rather than a Committee was based on a misinterpretation of CDA structure, and specifically that Councils held higher status. Given the current high profile and priority of activities of CDA Committees, this misinterpretation would be easily clarified.

The Roles and Responsibilities Committee agreed unanimously that the Committee structure is valid for Dental Specialties' purposes.

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ROLES AND RESPONSIBILITIES COMMITTEE

(ii) Term of Membership

The concerns of individual specialty groups in this area were reviewed. It was agreed that the terms indicated in the Draft Terms of Reference encouraged continuity, but were flexible enough to allow specialties to change members if desired. Staggered terms were considered advisable in establishing the committee, in order that turnover would not occur for all members in the same year. Representatives will be divided into two (2) or three (3) groups at random and their terms adjusted. For example, three (3) representatives will be considered to be in the first year of their first term, three (3) in the second year, first term and three (3) in the third year, first term.

(iii) Appointment of Chairman

Comments concerning the appointment of the Chairman by the Specialty Committee were considered. All Committee/Council Chairmen are appointed by the President on recommendation of the Executive Council. It was stressed that such appointments are done in consultation, and thus an avenue is available to consider the desires of the Committee on Dental Specialties. It was agreed that the appointment of a Chairman from amongst Committee members would not require a further appointment to the Committee.

(iv) CDA Representative

It was agreed that the Committee meetings should be attended by an elected official of CDA, to be determined at a later date. This would not be formalized in the terms of reference.

NOTE: Later in the meeting the Roles and Responsibilities Committee formalized a recommendation that called for executive liaisons to all Councils/Committees.

(v) Role of Observer (RCDC)

It was agreed that the term "observer" required no further clarification in terms of voting privileges. It was felt that the activities of this Committee were not such that frequent votes would be required.

ROLES AND RESPONSIBILITIES COMMITTEE

APPENDIX I

RESOLVED:

- 87.21 THAT the appended terms of reference for a CDA Committee on Dental Specialties be approved.

ADOPTED

3. Role of the Council on Student Affairs

November Executive Council discussion on this matter was reviewed. It was felt that while the Council provided an excellent vehicle for communicating the importance of organized dentistry to the student body, perhaps the resources of the Council could be utilized to greater benefit of the CDA and the students. It was generally felt that Executive Council could refer items, such as Capitation, to the Council for information and input. However, it was recognized that the annual turnover of membership on Council would impact on results of this type of activity.

A discussion on the scheduling and locale of the meetings of the Council and the Students Conference ensued. It was indicated that the Students Conference is held at little cost to CDA - it being to a large extent funded by a grant from CFDE. A major concern identified was that the Council and the Conference should not be held in isolation from CDA but rather, where possible, be held in conjunction with a major CDA activity, such as a Board of Governors Meeting or CDA Convention. This would foster a principal objective of developing awareness and establishing liaison between organized dentistry and the student body.

RESOLVED:

- 87.22 THAT the Council on Student Affairs have one annual Council meeting, funded by CDA, to be held in conjunction with a major CDA activity - Board of Governors Meeting and/or Convention.

THAT the Annual Students' Conference, whenever appropriate, be held in conjunction with a major CDA activity.

THAT a second meeting annually of the Council on Student Affairs be approved, if held in conjunction with the Students Conference, and be thereby subsidized by an alternate source of funding (CFDE).

ADOPTED

ROLES AND RESPONSIBILITIES COMMITTEE

Student Functions/Student Nights

The comments made by Executive Council on Student Functions were reviewed and endorsed. Effectiveness of these functions continues to be monitored by staff.

4. Geriatric Dentistry

The determination of CDA's role in the area of geriatric dentistry was discussed. The Committee agreed that Geriatric Dentistry transcended Council/Committee boundaries. After considerable deliberation, the Roles and Responsibilities Committee agreed to recommend the following:

RESOLVED:

- 87.23 (i) **THAT geriatric dentistry be encouraged and enhanced within existing CDA Councils and Committees.**
- (ii) **THAT Council/Committee Chairpersons be directed by Executive Council to report on on-going activities in the area of geriatric dentistry outlining present plans/programs in this area and potential future activities. Reports should target the September meeting of the Board.**
- (iii) **THAT a CDA situation analysis be prepared, within the same timeframe, delineating CDA's objectives in this area.**
- (iv) **THAT corporate bodies, licensing authorities, ACFD, and dental faculties be requested to comment on CDA's role in geriatric dentistry.**
- (v) **THAT further action to identify a specific existing or newly created area within the CDA structure for geriatric dentistry be deferred, pending review of all information requested.**

ADOPTED

The preliminary opinion of the Roles and Responsibilities Committee is that a specific Council/Committee for Geriatric Dentistry is not required at the present time.

ROLES AND RESPONSIBILITIES COMMITTEE

5. Board of Governors - Structure

Comments received from corporate bodies were reviewed and discussed. All those who had not provided written comment were contacted, and expansion of the existing Board structure to allow representation of ACFD, ODQ or other interest groups was not supported. Quebec and Manitoba were noted as supporting a seat for ACFD; Quebec also supported a seat for ODQ.

Members discussed the effectiveness of the non-voting Governors. It was agreed that their communication role would not be jeopardized if they were removed from the Board structure. A suggestion of a specific observers' section at Board Meetings to include government (Health & Welfare/Department of Veterans Affairs) representatives, and representatives of other National Dental Organizations was favourably received.

The Committee considered the underlying principle of Board membership to be based on representation of the individual CDA member, through a corporate body structure. The Student Governor is the only exception to the principle of representation through a corporate body structure, and allows for student member representation through a Student Affairs Council. An avenue allowing for duplicate representation cannot be permitted. The interests of the individual CDA member must remain paramount, and it would appear that special interest group representation is not possible if this principle is to be maintained.

RESOLVED:

87.24 THAT Membership on the Board of Governors is provided in order that individual members of the CDA are represented through a provincial corporate body or the Canadian Forces Dental Services.

In addition, the dental student members of CDA are represented on the Board through the Student Affairs Council. The principle underlying this system of representation on the Board is that each CDA member be represented once by a member on the Board. The principle of being represented more than once is not supported and therefore the existing voting structure of the Board is endorsed.

THAT the current structure of the Board of Governors remain the same.

ADOPTED

ROLES AND RESPONSIBILITIES COMMITTEE

RESOLVED:

87.25 THAT the following be invited to send a representative/spokesperson to meetings of the CDA Board of Governors at their own expense, and that such representatives/spokespeople be seated in a specially designated area:

- Association of Canadian Faculties of Dentistry
- Canadian Fund for Dental Education
- National Dental Examining Board of Canada
- Royal College of Dentists of Canada
- Canadian Dental Hygienists' Association
- Canadian Dental Assistants' Association

ADOPTED

In reviewing Board structure the Committee reaffirmed the previous decision of Executive Council concerning ODQ representation at the CDA Board; that a mechanism is available only through negotiation with the corporate body - the QDSA.

However, Committee felt a review of active members from Quebec should attempt to determine if licensed specialists are presently included in the count for Board seats. (Ref. Constitution & By-Laws - Article V - Section 2). As these individuals are ODQ members, and their true representation through the QDSA would be questionable, a mechanism for an ODQ seat may be found within the principles outlined above. An accurate accounting of active members in Quebec could well result in an additional seat on the Board.

6. Council/Committee Review

The Committee discussed the Council vs Committee structure, and the potential advantages of converting to a Committee structure. It was agreed that the flexibility aspect of Committees was a definite advantage when adjusting to the priorities of the Association. Council structure and membership is enshrined in the Constitution and By-Laws, and such features as corporate/regional representation are dictated through the Constitution. While it was agreed that the Constitution could be amended as required, the timing required is not always in tune with the immediate necessity to down-size or increase the membership on Councils.

ROLES AND RESPONSIBILITIES COMMITTEE

The Committee then discussed the need to identify the type of structure by certain activities, and then identify which groups fit into such structures.

The following structures were defined and approval of these definitions is recommended:

Two examples identified under the definition of Councils were the Executive Council, and the Council on Education and Accreditation.

RESOLVED:

87.26 THAT the following definitions be approved:

Councils

A Council is a body whose activities and membership must have the protection of the Constitution and By-Laws, so that a multi-review process is required for change. From the purview of the membership and/or the public, its activities should appear to be just, honest and its membership properly representative of the geographic regions of Canada. In addition, members must display certain talents and/or experience that qualify them for such responsibility.

Committees of Executive Council (Standing and/or Ad Hoc)

A Committee of Executive Council is a body which functions as a task oriented working group. Membership and size of these entities should be subject to determination by Executive Council as priorities dictate. Membership should be by appointment of the President on recommendation of the Executive Council, to ensure expertise requirements. Regional representation should be a consideration, but not a requirement.

Committees of the Board of Governors

A Committee of the Board of Governors is a body which maintains on-going long-term activities in which the Association considers involvement to be important. Such committees would be subject to

ROLES AND RESPONSIBILITIES COMMITTEE

the elective process. Regional representation (Atlantic, Pacific, Central) would be an important consideration in establishing the membership of these Committees.

ADOPTED

NOTE: The Roles and Responsibilities Committee is directed to carry out further investigation on the current CDA Councils/Committees structure to identify the type of structure needed by certain activities, and to identify which groups fit into these definitions.

The Committee members felt strongly that the national character of the Association could be maintained by utilizing the above categories, without jeopardizing the working effectiveness of the groups. The only category with mandatory representation would be "Councils", as defined through the Constitution.

7. Nominations, Awards and Trusts

RESOLVED:

87.27 THAT the Chairman of the Council on Nominations, Awards and Trusts be appointed annually by the President.

ADOPTED

DIRECTION: The Board of Governors directed the Council on Constitution and By-Laws to make the appropriate by-laws amendments.

8. Board of Governors - Interim Meeting

The background of Interim Meetings of the Board was reviewed, indicating that over the past several years, Interim meetings had become the norm rather than the exception.

It was agreed that, in almost all instances, an Annual Meeting of two (2) to three (3) days duration would suffice. The recommendation to have Chairpersons present reports of substance and political sensitivity to the Pre-Board Executive Council would lead to more efficient and therefore shorter Board meetings.

ROLES AND RESPONSIBILITIES COMMITTEE

RESOLVED:

- 87.28 THAT the operations of the CDA be geared to an Annual Meeting of the Board of Governors, and that Interim Meetings only be called by the President in exceptional circumstances.

DEFEATED

NOTE: Provisions in this regard are already contained in the CDA Constitution and By-Laws (Article VIII, Section 7).

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

9. Board of Governors - Reporting Structure

The Committee endorsed the existing procedure of Councils and Committees reporting to the Board through the Executive Council.

Considerable discussion ensued on the roles and responsibilities of Council/Committee Chairpersons and Executive Liaisons.

It was agreed that considerable benefit could be derived through having Council/Committee chairpersons present their reports to Executive Council on invitation.

The complexity of issues and political sensitivity of individual reports would determine where such personal reporting was required. In instances where a Chairperson was not required to attend the Executive Council, the Executive Liaison would present the report. The same criteria would be used to determine the necessity of Chairpersons being present at meetings of the Board of Governors. This would be a decision of the Executive Council.

10. Roles & Responsibilities of Executive Liaisons

APPENDIX II

The Roles and Responsibilities Committee discussed the role and responsibilities of Executive Liaisons. The following recommendations are put forth:

THAT all CDA Councils and Committees be assigned an Executive Liaison.

THAT responsibilities of Executive Liaisons include the following:

ROLES AND RESPONSIBILITIES COMMITTEE

- to communicate with the Executive Council/Board of Governors in the absence of the Chairman
- to act as a resource to Council/Committee Chairpersons providing guidance and advice on all areas of Association activities
- to monitor and advise on the progress of Council/Committee activities and their associated budgetary expenditures
- to provide advice and further clarification on the directives of Executive Council
- to consult with the Council Chairperson on the necessity of meetings. In the event of disagreement, the CDA President, as Chairman of Executive Council, would make the decision.
- to be aware of all activities of Councils/Committees to which they are assigned and to determine, in consultation with the Chairperson, if attendance of the Executive Liaison at meetings is cost-effective. Attendance at all Council/Committee meetings is not required.

Executive Council agreed to table this recommendation, to allow the Roles and Responsibilities Committee to amalgamate items from the current Terms of Reference.

11. Amalgamation of Existing Councils/Committees

In reviewing this area, the Roles and Responsibilities Committee felt that increased efficiency and cost-effectiveness should be apparent before change is recommended. The following decisions were reached:

Constitution and By-Laws/Ethics

The Committee felt that these two areas were quite different in character requiring different talents of their members. Further, no case could be made for cost savings, as these two Councils operate in a most efficient manner, utilizing Conference Calls and written communication.

ROLES AND RESPONSIBILITIES COMMITTEE

Consumer Products Recognition/Dental Materials & Devices

Although these two groups would appear to be "naturals" for amalgamation, further discussion indicated that entirely different qualities were required by their members.

Consumer Products Recognition (CPR) members deal in a highly visible, and at times controversial area, whereas the Dental Materials and Devices (DM&D) composition is academically-oriented. Both groups require expertise, but the character of the expertise is different.

Concern as to the size of DM&D was raised. However, reductions could be achieved, if a move to the new Committee structure were to be approved.

It was felt that the CPR Committee required revamping and revitalization, and that the membership required review. It was indicated that the Chairman was aware of this and was working toward more effective membership.

In discussing the role of CPR, it was agreed that the Committee's role in reviewing and approving advertising had definite benefits for the public and the profession. The potential for revenue from the industry relative to the Seal of Recognition was also discussed.

Hospital and Institutional Services/Health Care Council

The Committee could find no justification for combining these two areas.

Taxation Committee/Government Relations Committee

A previous indication that combination of these two Committees was being considered was questioned. Indications are that a case for cost-effectiveness would be very difficult to make.

In completing the preliminary review of Councils and Committees, the Roles and Responsibilities Committee confirmed that the utilization of an outside agency was not required.

12. Council - Executive Committee of Health Care

The question of communication between the Executive Committee of Health Care and the Council on Health Care was discussed briefly. Improvements in this area have occurred, and the problem appears to have been resolved.

ROLES AND RESPONSIBILITIES COMMITTEE

13. Distribution of Report of Council on Insurance and Investment

Dr. Roach indicated that he could not identify any valid reason for CDA to accede to a request, originating in Ontario, that the report of the Council on Insurance and Investment be circulated prior to and separate from the resource documents for meetings of the Board of Governors. The Committee agreed that no further action on this item was necessary.

14. Specialty Section Members - Membership in the CDA

The background to this topic was reviewed. The Board of Governors had previously approved a motion waiving the CDA membership requirement for dentists wishing to join a CDA recognized specialty section. In so doing, it was the understanding that membership in CDA by members of specialty sections would be reviewed annually, and that specialty sections would strive for a 75% membership in CDA. It was agreed that this item would be referred to the first meeting of the Committee on Dental Specialties, if the establishment of the Committee receives Board approval. It was recommended that each Specialty Section be informed annually of the percentage of their membership that are CDA members.

15. Role of the Immediate Past-President

The structure of the Management Committee was reviewed, particularly as it pertained to the role of the Immediate Past-President. The practice of having vice-presidents and president-elects, which exists in some provincial associations was also reviewed.

No justification supporting any change to the present management structure was found. In fact, it was felt that the Immediate Past-President role in sharing presidential workload, and acting as an elder statesman was of great value.

The Committee did feel, however, that the practice of all members of Management attending certain functions should be monitored and reviewed.

ROLES AND RESPONSIBILITIES COMMITTEE

Discussion continued on the cost factor of the Office of the President. There was some feeling that a maximum number of days for President's travel should be established. The practice of having others represent the President at certain functions was endorsed. Two year terms for the President were discussed, in relation to reduction in travel. No recommendations were made.

Respectfully submitted,

John Christie, Chairman
Roles & Responsibilities Cttee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Roles and Responsibilities Committee with appreciation.

COMMITTEE ON DENTAL SPECIALTIES

TERMS OF REFERENCE

I STRUCTURE

- (a) One representative appointed by the Specialty Organization representing each of the Dental Specialties recognized by the CDA
- (b) One observer named by the RCDC *
- (c) The Chairman to be appointed annually by the President of the CDA
- (d) Committee Membership be appointed for three year term, once renewable

II MEETINGS

- (a) One meeting annually to be held at CDA Headquarters or at a location approved by the Executive Council
- (b) If additional meetings are required, authorization by the Executive Council is necessary
- (c) The standing policy regarding CDA funding of meetings will apply

III RESPONSIBILITIES

- (a) To provide a forum for discussion of common interests and concerns of the specialists and/or specialty groups in Canada
- (b) To review and report on items referred to the Committee by the Executive Council
- (c) To report annually to the Executive Council on Committee's activities and recommendations

* Cost of RCDC Representative to be borne by RCDC

/msg

1987-03-05

TERMS OF REFERENCE

EXECUTIVE COUNCIL LIAISON

THAT Executive Council liaison be established with all other Councils of CDA.

THAT the following Management Committee recommendations re Guidelines and Terms of Reference for Executive Liaison appointees were adopted by the Board.

- 1) The Executive Liaison person will be a member of Executive Council and will be appointed annually by the President
- 2) Appointments will be made to Councils, Committees, etc. of the Association and will include all Committees and Sub-Committees of a Council, as a liaison duty.
- 3) Attendance will be required at all Council meetings possible and such other Committee and Sub-Committee meetings of Council which, in the opinion of the Executive Liaison person are deemed advisable.
- 4) The Executive Liaison person will be an ex-officio member of the Council without a vote on Council but with the right to attend all sessions of Council or Committees and/or Sub-Committees, including "in-camera" sessions.
- 5) The Executive Liaison person will be bound by the same rules of Councils, Committees and Sub-Committees as apply to elected Council members.
- 6) The Executive Liaison person will endeavour to convey and interpret all regulations, motions and opinions of the Board of Governors, Executive Council and the President to the Council, and in turn will endeavour to convey the opinions of the Council.

Adopted - 1977

CONVENTION COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Items for Information Not Requiring Board Action

1987 Joint CDA/ODQ Convention - May 24-28, 1987

1. Planning for the 1987 joint Convention proceeds on schedule. A joint CDA/ODQ planning committee has been formed and meets regularly to review programming activities.
2. Scientific Program
 - All speakers and program participants have been confirmed.
 - The Grieve Memorial Lecture will be held on Thursday, May 28 and Dr. Charles J. Burstone has been confirmed as presenter. Dr. Burstone was recommended by the Canadian Association of Orthodontists and accepted by both CDA and ODQ.
 - The CDA/Dentsply Student Table Clinic Program is scheduled as follows:

Monday, May 25	Private judging of student clinics
Monday, May 25	Dentsply Dinner honouring Student Clinicians
Tuesday, May 26	Presentation of clinics to convention delegates
 - Plans are currently underway to include a panel discussion on capitation, and a presentation on dental awareness programming for the dental office.
 - Simultaneous translation will be available for select lectures and presentations.
 - Dental auxiliaries, office staff, dental technicians and spouses are all eligible to attend the convention. Special programs have been planned for each group.
 - Two days of "hands on" pre-convention courses in both English and French will be held prior to the official start of the open sessions.

CONVENTION COMMITTEE

3. Social Program

- A gala Presidents' Evening and Casino Night will be held on Tuesday, May 26 at the Meridien. Profits from the Casino Night will be donated to charity.
- A Hospitalité Québécoise fun night will be held on Wednesday, May 27 at the Meridien.

4. Publicity/Promotion

App.I

- A preliminary convention program was sent to all CDA members in early February. Non-members will receive this mailing later in February.
- To all dentists outside of Quebec, the convention has been promoted as a Canadian Dental Association convention, in conjunction with Les Journées Dentaires.
- To Quebec dentists, the convention has been publicized as Les Journées Dentaires 1987 - a joint convention of the Canadian Dental Association and the Order of Dentists of Quebec.
- The final convention program will be mailed to all registrants in May. Additional copies will be available on-site.
- A special early bird draw for all dentists who pre-register before March 24, 1987, will be held. The prize will be two round-trip tickets to anywhere Air Canada flies, except Bombay and Singapore.
- The CDA Journal has provided extensive coverage of the joint meeting as has the ODQ Journal.

5. Registration

- All ODQ members, via their license fee, will be allowed complimentary access to the convention, and attendance at three luncheons.
- All CDA members will be charged \$150.00 to attend. Non-members will pay \$275.00 for the same package.
- The Convention Committee is budgeting for a minimum of 200 out-of-province delegates.

CONVENTION COMMITTEE

6. Exhibits

To date, 263 exhibit booths have been sold. This is an increase of fifty booths to that sold in 1986 at Les Journées Dentaires. The sale of additional booths will be used to support the added costs incurred by the joint meeting.

7. Hosting

Les Journées Dentaires will host CDA officials at the meeting and will provide:

- accommodation for the President, President-Elect and the Executive Director at the headquarters hotel, the Meridien;
- complimentary registrations for CDA VIP's, staff and special guests;
- required meeting room space, if necessary.

The President of the American Dental Association, Dr. Joseph Devine, has expressed a desire to attend this meeting, and a special invitation has been extended to Dr. Devine.

8. CDA Profile

Discussions are underway to hold a joint CDA/ODQ press conference. This has yet to be confirmed. The CDA President will also address the membership at the luncheon on Thursday, May 28, 1987. All written promotional literature has also stressed the joint nature of the convention.

1988 Convention - Edmonton, Alberta, August 21-24, 1988

1. The convention committee is pleased with the change of date and feels that it will yield a greater registration from dentists and auxiliaries wishing to holiday in the Canadian Rockies.
2. An official organizing committee has been struck and planning has begun.
3. Convention activities will be centred at the Edmonton Convention Centre, and the Westin Hotel will be the headquarters hotel.

CONVENTION COMMITTEE

4. Discussions to date have centred on the development of a convention theme and obtaining a keynote speaker.
5. A registration package is being developed to accommodate Alberta dentists who have paid a \$50.00 convention fee via their Alberta Dental Association fee.
6. CDHA and CDAA Chairmen have been identified and programming will incorporate these two groups.
7. Letters have been forwarded to specialty and affiliate groups concerning their intent to meet in conjunction with the CDA meeting.
8. Convention publicity will indicate that this is a CDA convention hosted by the Alberta Dental Association.
9. The CDA Board of Governors is scheduled to meet prior to the convention on August 19-20, 1988, in Edmonton.

1989 Convention - Vancouver, British Columbia

Discussions are currently underway to hold the CDA convention in Vancouver, B.C. in 1989. Tentative dates of August 27-30 have been set aside.

Final dates will be publicized once the availability of suitable facilities and accommodation has been confirmed.

Respectfully submitted,

Linda Teteruck
Director of Communications

ADOPTION OF REPORT

The Board of Governors accepts the report of the Convention Committee with appreciation.

CONVENTION REGISTRATION POLICIES

The following is a list of complimentary registrations provided at CDA conventions.

Scientific Program

The Scientific Chairman has some discretionary powers in this area, the costs of which are factored into the scientific program budget. CDA's traditional practice includes:

1. A full convention registration package, including social tickets, for all key clinicians. A complimentary spousal package is provided should they bring their wives. Keynote speakers are also provided transportation costs, a living allowance and an agreed-upon honoraria. President's Ball tickets are provided at the discretion of the Chairman.

Table clinicians are provided an access badge for the day of their presentation only, no social tickets are included. Student clinicians are provided a full registration package, including social tickets but no President's Ball tickets.

Individuals who have been designated hosts for clinicians, (room monitors, etc.) are provided an access badge, no meal tickets.

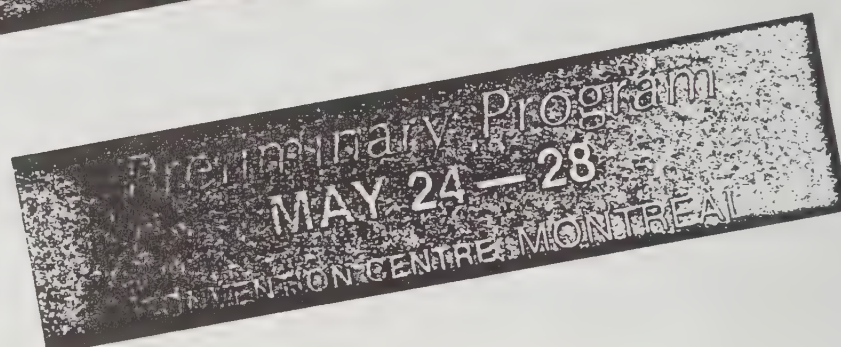
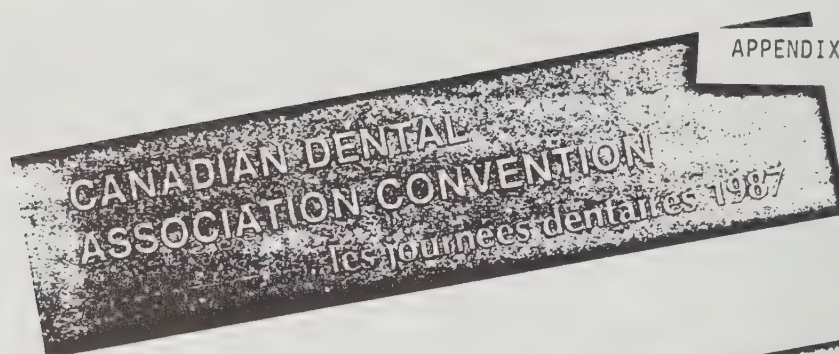
2. The Management Committee is provided a complimentary registration package, including social tickets and President's Ball tickets. Their spouses receive complimentary spousal package. The Executive Director and his spouse receive a similar package, as does the Chairman of the Board.
3. Executive Council members attending the convention pay for their registration packages and are then reimbursed by CDA. This includes a spousal package.
4. Past Presidents receive a full complimentary registration package, including all social tickets, except President's Ball tickets.

Honorary members receive the same entitlement.

The spouses of Past Presidents and Honorary Members are not included.

5. Life members and student members receive free access to the scientific sessions and exhibits. No social tickets are provided.

6. Core Convention Committee members receive a full complimentary registration package including two tickets to the President's Ball. A complimentary spousal package is only provided if their spouse is an active member of the Spouse's Committee. Spousal Committee members are provided with a spousal package.
7. Local Convention helpers are provided with a name badge only and a meal allowance when applicable. No social tickets are provided.
8. The CDA Convention Chairman, for the next CDA Convention (and his/her spouse or helper) are provided with a complimentary Convention registration and full social ticket package.
9. The Executive Director and President of the host province receive a full complimentary package.
10. CDA also traditionally invites the Presidents of the British Dental Association, American Dental Association, Canadian Medical Association, Canadian Pharmaceutical Association and FDI, and their wives to the convention. A full complimentary registration package is provided for both the President and spouse.



JOINT CONVENTION OF THE CANADIAN DENTAL ASSOCIATION
AND THE ORDER OF DENTISTS OF QUEBEC

PRE CONVENTION

SUNDAY, MAY 24



FRANK FAUNCE, D.D.S.
Atlanta (Georgia)

9:00 — 12:00 a.m.
1:30 — 4:30 p.m.

GLASS RESTORATIONS IN CURRENT AESTHETIC DENTISTRY

- I. An introduction to glass materials being used in clinical dentistry
 - A. Composite resin systems — an update
 1. Restorations
 2. Bonding or cementation of inlays, onlays and laminate veneers
 - B. Laminate veneer systems
 1. Acrylic
 2. Composite
 3. Porcelain
 4. Ceramic
 - C. Inlays and onlays
 1. Composite
 2. Porcelain
 3. Ceramic
- II. Color systems for glass restorations
 - A. Color optics
 1. How color works
 2. Color systems
 - a. Composites
 - b. Porcelain
 - c. Ceramic
 - B. Use of color systems clinically
- III. Clinical techniques
 - A. Laminate veneers of porcelain and ceramic
 - B. Inlays and onlays of porcelain and ceramic
 - C. Composite build-ups
- IV. Summary — questions and answers

The presentation on glass systems currently in use for aesthetic dentistry concentrates on the practical application of basic science theory in modern dental practice. The presentation gives an update on the state of the clinical art with composite resins as well as porcelain veneer clinical applications. The program is designed to take the mystery out of the use of these latest materials and relate their use in everyday dentistry.

HANDS ON COURSE

PREDICTABLE ENDODONTICS FOR THE GENERAL PRACTITIONER

Instructor: Dr. Bernard H. Dolansky, Ottawa (Ontario)
et al

Theory: 8:30 — 12:00 a.m.

Practice: 1:30 — 4:30 p.m.

(also available in French on the same day)

The subject matter will deal with case selection and diagnosis on a strictly clinical basis. The emphasis is on PREDICTING problems before they occur. We will also discuss emergency procedures and again the message conveyed is how to make a quick accurate diagnosis that allows us to institute a treatment yielding predictable relief. The final half of the didactic presentation will concentrate on the preparation of root canals quickly and easily to allow for the latero-vertical condensation of gutta percha.

Attendance in this hands on course is limited to ensure that each participant receives the highly individualized instruction necessary to improve performance in this important area, with attention to:

- how to prepare access cavities which make cleansing and shaping easy
- cleansing and shaping techniques that permit easy obturation
- how to avoid common pitfalls and what to do when they occur
- obturation for predictable results

(materials and instruments to be supplied by participants)

RESERVATIONS REQUIRED
(see registration form)

Course limited to 40 participants

PRE-CONVENTION

LIMITED ATTENDANCE COURSE

MONDAY, MAY 25



9:00 — 12:00 a.m.
1:30 — 4:30 p.m.

MEL M. TEKAVEC, D.D.S., M.A.G.D.
Pueblo (Colorado)

THE METAMORPHOSIS IN DENTISTRY

This is a full-day program concerning the many phases of change in practices that are facing dentists today. The following subjects will be addressed in depth:

METAMORPHOSIS IN DENTISTRY

Problems Facing Us Today With Solutions

INTERNAL MARKETING

Revitalization of Your Present Practice

TREATMENT CONFERENCE

The Nine Motivating Factors That Make Patients Say "Yes"

TAMING THE INSURANCE MONSTER

Alphabetical — AGED — Mailed Daily for Payment Without a Computer

SCHEDULING

Treatment Room Scheduling; Replacing the Inefficient, One Column, Fifteen-Minute Appointment Book

PERSONNEL

Job Description
Salary Survey
Performance Appraisal
Team Bonus System

FACILITY DESIGN

Tips to Improve Your Present Office Efficiency

SOLO GROUP

How To Bring in an Associate and Still Keep Your Individuality

Dentists are encouraged to bring their entire staff as Dr. Tekavec promises that they will be motivated to implement any needed changes!

HANDS ON COURSE

ESTHETIC TECHNIQUES USING COMPOSITE RESIN BONDING

Instructor: Dr. Denis Robert Quebec (Quebec)

Theory: 8:30 — 12:00 a.m.

Practice: 1:30 — 4:30 p.m.

Presentation in French only

RESERVATIONS REQUIRED
(see registration form)

Course limited to 40 participants

CONVENTION

TUESDAY, MAY 26

English program

SONICS, ULTRASONICS AND LASERS
IN ENDODONTICS (all day)

Dr. Kenneth Zakariassen, Halifax (Nova Scotia)

RESTORATIVE DENTISTRY — A COMMITMENT
TO EXCELLENCE (all day)

Dr. Reuben R. Roach, St. Petersburg (Florida)

*(in collaboration with the
Quebec Corporation of Dental Technicians)*

SEX AND INTIMACY (all day)

Dr. Domeena C. Renshaw, Maywood (Illinois)

COMMUNICATIONS IN A DENTAL OFFICE (all day)

Ms. Jennifer M. de St. Georges, Monte Sereno (California)

HEART-SAVER COURSE with certification (all day)

Dr. Peter Vaktor, Montreal (Quebec)

(limited to 36 persons)

PROJECTED CLINICS (all day)

TABLE CLINICS (p.m.)

French program

L'EVEIL DES IMPLANTS DENTAIRE (a.m.)

Dr. William B. Donohue, Montreal (Quebec)

PROTHESES PARTIELLES AMOVIBLES: DU PLAN
DE TRAITEMENT ET DU DESSIN A LA MISE
EN BOUCHE (a.m.)

Dr. Claude Lamarche, Montreal (Quebec)

PERIODONTIE: PRESENTATION DE CAS ET
DISCUSSION (a.m.)

Dr. Roger Issa, Montreal (Quebec)

L'ATM ET L'OCCLUSION.

RECHERCHE DE L'HARMONIE (a.m.)

Dr. Pierre Larose, Montreal (Quebec)

DENTISTERIE COSMETIQUE (p.m.)

Dr. Pierre Lamontagne, Montreal (Quebec)

CURETAGE ET CHIRURGIE MUCOGINGIVALE (p.m.)

Dr. Allen Shapiro, Montreal (Quebec)

TABLE CLINICS (p.m.)

all day	=	9:00 — 11:30 a.m. & 1:30 — 4:00 p.m.
a.m.	=	9:00 — 11:30 a.m.
p.m.	=	1:30 — 4:00 p.m.

WEDNESDAY, MAY 27

English program

EVOLUTIONARY CHANGES IN OVERDENTURE
CONCEPTS (all day)

Dr. Robert M. Morrow, San Antonio (Texas)

DYNAMIC PERIODONTICS FOR THE
GENERAL PRACTITIONER (all day)

Dr. Gary M. Reiser, Swampscott (Massachusetts)

COMPUTERIZED FABRICATION OF CROWNS (all day)

Prof. François Duret, Le Grand Lemps (France)

CONTEMPORARY ORAL AND MAXILLOFACIAL
SURGERY: DENTAL IMPLANTS

RIGID FIXATION (all day)

Dr. Joseph E. Van Sickels, Houston (Texas)

PROJECTED CLINICS (all day)

TABLE CLINICS (p.m.)

French program

REANIMATION CARDIO-PULMONAIRE
avec certification (all day)

Dr. Peter Vaktor, Montreal (Quebec)

Course limited to 36 persons

PROJECTED CLINICS (all day)

AMELOGÉNESE: REVUE HISTOLOGIQUE ET
DEVELOPPEMENTS RECENTS (a.m.)

Dr. Antonio Nanci, Montreal (Quebec)

ÉVALUATION CLINIQUE DU PATIENT

GERIATRIQUE (a.m.)

Dr. Rénald Pérusse, Quebec (Quebec)

TRIBUNAL SIMULE (a.m.)

L'IMPLANTATION DU PROGRAMME D'HYGIENE
BUCCO-DENTAIRE POUR LES BENEFICIAIRES
HEBERGES DANS LES CENTRES D'ACCUEIL (a.m.)

Dr. Marcel Paul Tenenbaum, Montreal (Quebec)

(Program of the Quebec Corporation of Hygienists)

LE CONTRÔLE DE L'INFECTION EN

CABINET DENTAIRE (a.m.)

Dr. Monique Michaud, Montreal (Quebec)

(Program of the Quebec Association of Dental Assistants)

LA PREVENTION EN PROTHESE COMPLETE (p.m.)

Dr. Richard Taché, Montreal (Quebec)

ESPACE PROTHETIQUE MANDIBULAIRE
GERONTOLOGIQUE ET PIEZOGRAFIE (p.m.)

Dr. Abderrahman Nabid, Alger (Algérie)

AGRANDISSEZ VOTRE CLIENTELE EN
SORTANT DE VOTRE CABINET (p.m.)

Dr. Jean-Robert Vincent, Montreal (Quebec)

CONVENTION

WEDNESDAY, MAY 27

French program

LA GERONTOLOGIE ET SES MYTHES (p.m.)
Dr. Hélène Lemay, Montreal (Quebec)

TABLE CLINICS (p.m.)

TECHNIQUE DE LABORATOIRE (p.m.)
Mr. Jean-Marie Boulanger, Montreal (Quebec)
(Program of the Quebec Association of Dental Assistants)

**IN ADDITION TO THE GENERAL PROGRAM,
SPECIAL LECTURES ARE PLANNED FOR:**

- HYGIENISTS
- ASSISTANTS
- TECHNICIANS
- ADMINISTRATIVE STAFF

**A HEALTH ASSESSMENT CLINIC
WILL BE AT THE DISPOSAL OF ALL DENTISTS
AT THE CONVENTION CENTRE
ON TUESDAY, MAY 26 AND WEDNESDAY, MAY 27**

TESTS PERFORMED

Pulmonary function
Audiometry
Glaucoma testing
Visual acuity
Electrocardiogram
Body fat evaluation

Blood testing:
• hepatitis antibody
• mercury
• SMA 18
• CBC
• electrolytes

RESERVATIONS REQUIRED
(see registration form)

EXHIBITORS

Tuesday	9:00 a.m. — 5:30 p.m.
Wednesday	9:00 a.m. — 5:30 p.m.
Thursday	9:00 a.m. — 12:00 a.m.

THURSDAY, MAY 28

English program

CLINICAL TECHNIQUES THAT PROVIDE
PREDICTABLE RESULTS WITH DIRECT
RESTORATIVE MATERIALS (a.m.)
Dr. Ernest G. Ambrose, Saskatoon (Saskatchewan)

PROJECTED CLINICS

French program

LES MODES DE REMUNERATION (a.m.)
Dr. Claude Chicoine, Montreal (Quebec)

LES BIOMATERIAUX DENTAIRE — UNE REVUE (a.m.)
Dr. Ralph Y. Barolet, Quebec (Quebec)

LA DOULEUR ET LES DYSFONCTIONS DE
L'APPAREIL MANDUCATEUR (a.m.)
Dr. Gilles Lavigne, Rockville (Maryland)

LES CLICHES RADIOGRAPHIQUES DES
MAXILLAIRES: COMMENT EN SOUTIRER
LE MAXIMUM D'INFORMATIONS (a.m.)
Dr. Jean-Paul Goulet, Quebec (Quebec)
(Program of the Quebec Corporation of Hygienists)

PROJECTED CLINICS (a.m.)

SPOUSES

SEX AND INTIMACY

Dr. Domeena C. Renshaw
Tuesday, May 26 — all day

CITY TOURS

Scientific Program (see preliminary program)

SOCIAL PROGRAM

PRESIDENT'S BALL AND CASINO EVENING
Meridien Hotel

Tuesday, May 26 — 8:30 p.m. to midnight

RENDEZ-VOUS '87 EVENING

Meridien Hotel

Wednesday, May 27 — 9:00 p.m. to 2:00 a.m.

EARLY-BIRD REGISTRATION:

DENTISTS WHO PRE-REGISTER
BEFORE MARCH 24, 1987
WILL BE ELIGIBLE FOR A DRAW
OF TWO ROUND-TRIP TICKETS
TO ANY AIR CANADA DESTINATION
(except Bombay and Singapore)

AIR CANADA CONVENTION CENTRAL



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weekdays 9:00 a.m. to 8:00 p.m. EDT/EST**

*Certain advance purchase conditions apply

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Committee Members: Dr. R.Y. Barolet, Chairman, Quebec
Dr. W.B. Chapple, Ontario
Dr. M. Eggert, Alberta
Dr. G. Nikiforuk, Ontario
Dr. J. Speck, Ontario
Dr. W.C. Sturtridge, Ontario

Observer: Dr. T. Dubas, Health Protection Branch,
Health & Welfare Canada

1. Committee Meetings

The committee has met twice since the last report to the Board, on September 29, 1986 and January 19, 1987.

Items Requiring Board Action

2. Anti-plaque Guidelines

The Committee has completed its development and review of guidelines for plaque removal as applied to dentifrices and mouth rinses.

The Guidelines have been developed based on the Guidelines of the American Dental Association, but they have been modified for use in Canada and reflect comments from dental educators at all of the Canadian faculties of dentistry.

The major changes which have been incorporated are as follows:

1. more complete documentation of the study is required;
2. better information about the types of patients in the study is required; and
3. an actual target of clinically acceptable gingivitis levels, not just a percentage reduction, has been incorporated.

It should be noted that, in spite of the revisions, any good study which meets the ADA guidelines should be able to meet those of the CDA as well.

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

The CDA Guidelines appear in Appendix I. For your ease of reference, we have marked areas which differ from the ADA guidelines.

APPENDIX I

RESOLVED:

- 87.29 THAT the documents "Guidelines for Acceptance of Chemotherapeutic Products for the Control of Supragingival Dental Plaque and Gingivitis" and "Chemotherapeutic Products for the Control of Supragingival Dental Plaque and Gingivitis" be approved; and,

THAT subsequent implementation be conducted by the Committee for Consumer Products Recognition.

ADOPTED

RESOLVED:

- 87.30 THAT the accompanying statement for the new seal of recognition be as follows:

(Product Name) contains (ingredient)
which is, in our opinion, an effective agent for the control of supragingival plaque accumulation and gingivitis, and is of significant value when used in a conscientiously applied program of oral hygiene and regular professional care of periodontal diseases. This product has not been shown to control existing periodontitis.

ADOPTED

The CDA contract with Seal of Recognition Holders will be reviewed following Board approval of the guidelines and appropriate revisions will be incorporated.

A special vote of thanks is extended to Dr. Michael Eggert for his work on the Guidelines.

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

- 3 -

Items for Information - Not Requiring Board Action

3. Comparative Advertising

The Committee has reconsidered its position on comparative advertising and it has been suggested that comparative advertising could be accepted for cosmetic claims, but not for therapeutic claims. This issue is currently before CDA's lawyer, Mr. Ken Murchison, Q.C., for his opinion on a possible wording. He is also undertaking a general review of the standard agreement with Seal of Recognition Holders.

4. Colgate Junior Toothpaste

Colgate Junior Toothpaste was approved by the Committee at its January meeting. The toothpaste is targeted for young children.

5. "The Facts About Tartar" Pamphlet

The Committee has reviewed the Colgate pamphlet entitled "The Facts About Tartar" and found a number of points of concern. (See Appendix II). Committee members felt that, as the CDA seal and statement appear on the pamphlet, the areas of concern should be examined in detail and corrected, where appropriate. Colgate has been asked to look into the questionable areas.

APPENDIX II

Respectfully submitted,

Ralph Y. Barolet, DDS, MSD
Chairman,
Committee for Consumer Products
Recognition.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Committee for Consumer Products Recognition with appreciation.

Copy annotated to show where CDA
guidelines differ significantly
from ADA guidelines

GUIDELINES FOR ACCEPTANCE OF CHEMOTHERAPEUTIC PRODUCTS FOR APPENDIX I
THE CONTROL OF SUPRAGINGIVAL DENTAL PLAQUE AND GINGIVITIS

Consumer Product Recognition Committee
Canadian Dental Association

The Consumer Product Recognition Committee of the Canadian Dental Association will use the following criteria in evaluating chemotherapeutic products for the control of supragingival (above the gumline) plaque and gingivitis. The guidelines conform to the American Dental Association Plaque Control Guidelines with modifications based on the report of the Conference on Clinical Trials in Periodontal Diseases held in Chicago in May 1985 and reported in the Journal of Clinical Periodontology 13, 336 - 549 (1986). The guidelines do not describe criteria for evaluating the management of periodontitis or other periodontal diseases, nor will they describe the evaluation of products strictly for the mechanical removal of plaque. Both over-the-counter and prescription-only products such as mouthrinses and toothpastes containing active chemotherapeutic agents will be considered using these guidelines.

The clinical benefit of supragingival plaque control can best be demonstrated by a significant reduction in gingivitis. Therefore, it will be necessary to demonstrate a clinically and statistically significant reduction in gingivitis by the products. These clinical findings can be supplemented by information on total plaque levels and levels of specific periodontal pathogens. This places evaluation of anti-gingivitis products on the same clinical biological basis that is already applied to anti-caries products.

We are interested in stimulating research and commercial development of home care agents capable of producing clinically acceptable reduction in gingivitis. Therefore we have set an initial target of clinically significant control of gingivitis, as a mean gingival index of 0.75 per patient when measured on the scale of Loe and Silness or clinically equivalent index that includes a measure of sulcular bleeding.

SUMMARY OF GUIDELINES FOR CLINICAL STUDIES OF SAFETY AND EFFICACY

The Committee requires adequate information with the following characteristics for evaluation of any product used to control plaque and gingivitis chemotherapeutically.

- * Characteristics of the study population should represent typical product users.
- * Reporting the periodontal index (Russell's Index or equivalent) for each study group at initiation of the study, or initiation of each study period, will indicate the type of patients in which agents have been tested.
- * Active product should be used in normal regimen in comparison with a placebo control, or where applicable, an active control. Patient assignment to test groups should be at random.
- * A log must be kept of mechanical plaque control measures.
- * Studies should be a minimum of six months in duration.
- * Parallel or cross-over studies are acceptable but cross-over studies must have a sufficient latent period.
- * Two studies conducted by independent investigators will be required.
- * Microbiological sampling should estimate plaque qualitatively in addition to

indices which measure plaque quantitatively.

- * Plaque and gingivitis scoring and microbiological sampling should be conducted at baseline, six months and at an intermediate time and must include a measure of sulcular bleeding.
- * Microbiological profile should demonstrate that pathogenic or opportunistic microorganisms do not develop over the course of the study.
- * The toxicological profile of products should include carcinogenicity and mutagenicity assays in addition to generally recognized tests for drug safety.
- * The main reasons for study drop outs must be recorded and reported.
- * The basic unit of statistical analysis and reporting is to be the patient.

Copy annotated to show where CDA
guidelines differ significantly
from ADA guidelines

CHEMOTHERAPEUTIC PRODUCTS FOR THE CONTROL OF
SUPRAGINGIVAL DENTAL PLAQUE AND GINGIVITIS

CONSUMER PRODUCT RECOGNITION COMMITTEE
CANADIAN DENTAL ASSOCIATION

These guidelines conform to the American Dental Association Plaque Control Guidelines with modifications based on the report of the Conference on Clinical Trials in Periodontal Diseases held in Chicago in May 1985 and reported in the Journal of Clinical Periodontology 13, 336 - 549 (1986).

The role of dental bacterial plaque as a factor in the development of oral diseases such as dental caries and periodontitis has been clearly recognized by the dental community as a result of scientific investigations spanning many years. Gingivitis also has a direct association with dental plaque. Dental professionals devote considerable time and effort in their clinical practices to educating patients about the role of dental plaque in oral diseases and the need to remove it on a regular basis. This patient education includes instruction in mechanical plaque control by thorough oral cleansing with a toothbrush and dentifrice in conjunction with regular use of dental floss and other interdental cleaning aids. This patient education may also include use of chemotherapeutic agents for control of plaque in addition to routine methods of mechanical plaque control.

The purpose of these guidelines is to outline the criteria which the Consumer Product Recognition Committee of the Canadian Dental Association will use in evaluating commercial products for its acceptance programme for the control of supragingival dental plaque and gingivitis through use of chemotherapeutic agents. Products which control supragingival plaque primarily by the mechanical removal of plaque will not be considered in these guidelines. Products for chemotherapeutic plaque control may incorporate agents for control of caries or for desensitization but evaluation of the clinical benefits of plaque control by these products will be those of the present guidelines. The Committee will evaluate both prescription and non-prescription drugs.

Examples of products for the chemotherapeutic control of supragingival plaque would be mouthrinses and dentifrices containing agents which would destroy or inhibit plaque microbiological growth and those which inhibit the attachment of these microorganisms to their natural sites. Current scientific evaluations in the dental literature suggest that the Committee should consider for acceptance products intended only for control of supragingival plaque and gingivitis and not of periodontitis. Commercial presentation of accepted products for plaque and gingivitis control through intra-oral topical application must state clearly 1) the inability to control existing periodontitis, 2) the possibility of development of new periodontitis while the product is being used, 3) the need for continuing professional periodontal care.

These guidelines are not intended to be a comprehensive review of the literature on the subjects of dental plaque, gingivitis and periodontitis. In this document the following terms and definitions will be used.

DENTAL PLAQUE (MICROBIAL DENTAL PLAQUE)

A highly variable substance resulting from the colonization and growth of microorganisms on the surfaces of teeth and oral soft tissues that consists of different microbial species embedded in an extracellular matrix composed of bacterial products and host secretory proteins. Dental plaque is found both supragingivally (above the gumline) and subgingivally (below the gumline) as well as on gingival epithelium and other oral surfaces such as dental restorations and oral appliances.

As supragingival plaque accumulates on an initially clean tooth surface it changes from a relatively simple Gram-positive coccal microflora to a more complex flora consisting of Gram-positive rods and cocci, Gram-negative rods and cocci and motile organisms such as Spirochaetes. This increasingly complex flora is associated with a shift from predominantly aerobic organisms to predominantly anaerobic organisms. This microbial population shift takes place over a period of two weeks so that within three to four weeks, when gingivitis is well established, there are many different microbial species in mature undisturbed dental plaque.

GINGIVITIS

A non-specific term that denotes inflammation of the marginal and interdental gingivae without reference to the etiology or cause of the problem. Scientific studies have shown that plaque-associated gingivitis can be controlled or prevented by removing and or inhibiting microbial plaque accumulation.

PERIODONTITIS

A non-specific term that denotes inflammation and destruction of the periodontium without reference to the etiology or cause of the problem. Apical migration of epithelial attachment, loss of collagenous connective tissues and loss of alveolar bone characterize the condition. The condition is commonly associated with extrinsic factors such as plaque and calculus but in some cases is associated in addition with systemic diseases such as diabetes, neutropenia and epidermal disorders.

If supragingival plaque accumulation is not controlled, plaque growth proceeds subgingivally into the gingival sulcus or crevice around each tooth. This extension of plaque subgingivally is important because adequate mechanical removal and chemical control of subgingival plaque is impossible for patient home care and requires professional intervention. There has not as yet been adequate scientific clinical evaluation of the ability of patients to control subgingival disease through home care employing either mechanical or chemotherapeutic measures.

GUIDELINES FOR ACCEPTANCE OF PRODUCTS

The guidelines will address the chemotherapeutic control only of supragingival plaque-associated gingivitis and not of periodontitis associated with subgingival plaque. Development of agents that control gingivitis is a useful and logical initial approach to development of agents that may eventually control periodontitis. Further studies may reveal a need for agents that achieve more than simply the control of gingivitis in the prevention and

control of periodontitis.

In evaluating products the Consumer Product Recognition Committee recognises that the benefit of plaque control is best demonstrated by evidence of a clinically significant reduction in gingivitis. Plaque and gingivitis are measured independently as clinical phenomena. Because gingivitis is the actual clinical biological problem to be controlled, in the Committee's review of products for acceptance it will be necessary to demonstrate clinically and statistically significant reductions of the manifestations of gingivitis. This places evaluation of anti-gingivitis products on the same clinical biological basis that is already applied to anti-caries products. Reductions in total plaque may be reported but any clinical findings would be strengthened to a much greater extent if accompanied by microbiological evidence of decreased levels of periodontal pathogens as a result of use of the agent.

As an initial working objective the committee sets, a level of clinically acceptable gingivitis per patient at 0.75 with the Loe and Silness gingival index or a clinically equivalent index. This level of clinical gingivitis in a patient implies that many of the sites have a clinical gingivitis level of 1.0 (no sulcular bleeding) and a considerable proportion have a clinical gingivitis level of zero.

We have set this level of clinical effectiveness because it is the intention of the committee to stimulate research and commercial development of new chemotherapeutic agents capable of clinically successful reduction of gingivitis when employed in a home care programme. We recognize that agents such as chlorhexidine available on prescription in Europe and North America are capable of at least this level of control of gingivitis and therefore provide a useful therapeutic target for a home care agent.

We are also requesting that for the experimental and placebo groups of patients the mean level of periodontitis and its range be reported in terms of Russell's periodontal index, or an equivalent periodontal index. This information is required only for the initial examination at the time of entry of the patients into the study. Although it is the purpose of these guidelines only to evaluate agents active in treating or preventing gingivitis, provision of this information will indicate to the committee the overall level of periodontal health of the patient groups in which the agents intended to control gingivitis have been tested.

REVIEW OF CLINICAL STUDIES

For any evaluation of a product to control plaque chemotherapeutically the Committee requires adequate information with the following characteristics.

Studies must be conducted with test populations and test conditions that represent the natural conditions under which the product is expected to be used. For example, both sexes must participate in the study; the age of the study population must be representative of those patients for whom the product is intended; the frequency and duration of use of the product must be representative of actual use of the product in practice; the user should be instructed in the proper use of the product but not necessarily supervised. A log of mechanical plaque control home care must be kept in view of the known effect of such home care on chemotherapeutic plaque control. In each study the

active product must be compared with a placebo control lacking the active agent but comparable in other ways. Patients must be assigned randomly to the active versus placebo groups. As new information develops in this area and products are recognized as effective, it may be possible in the future to compare products to an active control in addition to a placebo control.

Study designs employing either parallel or cross-over groups are acceptable providing that in a cross-over design study an adequate latent period is left between study periods. As a result of the length of the studies required for adequate evaluation of product efficacy the cross-over design will be significantly longer than the parallel design and may therefore be impractical. Periodontal indices must be reported for the beginning of each active phase in a cross-over study.

Studies assessing the ability of a chemotherapeutic agent to inhibit or reduce plaque formation and to measure the subsequent effect on gingivitis must be a minimum of six months in duration. Longer periods are preferable. Scoring should be conducted at baseline and at six months. An intermediate point for scoring should also be included during the first three months of the study. Two studies of at least six months duration conducted by different, independent investigators will be required.

Study periods of at least six months are required for several reasons. Within three months supragingival plaque that is not readily removed by mechanical means will have matured. It will then be possible to assess the effect of that matured plaque on the marginal gingival tissues. After this interval the patients will have had sufficient time to adapt to the study conditions and are more likely to be using the product under true conditions of home use. It is anticipated that adaptive changes in the oral flora are likely to occur within six months so that overgrowth of opportunistic organisms may be observed. Studies of longer duration are more likely to observe such phenomena.

| All study drop-outs must be followed up and a reason for their leaving the study recorded and reported.

GINGIVITIS

Clinical indices for evaluating the gingivitis that is related to plaque reduction in clinical studies should meet at least four basic criteria. The indices should be simple to use with a minimum of time and expense; criteria for assessing the stages of gingivitis should be clear and understandable; the clinical manifestations of the disease process should be measurable at all stages; and the data from the index should be amenable to statistical treatment. Several numerical indices are described in the literature. However, for a well controlled clinical trial, it is essential that accurate indices to assess the proper severity of the condition and the localized effect of treatment be used.

It is suggested that methods be selected which measure gingivitis using both subjective and objective criteria. For example, those indices which rely upon subjective examiner observation of the color tissue or an estimate of the degree of tissue swelling should be supplemented by methods which tend to use more objective measures such as whether sulcular bleeding occurs upon probing, or the amount of gingival crevicular fluid is measured. Presentation of

results that incorporate sulcular bleeding as a component of the measurement, such as the gingival index of Loe & Silness, would provide greater scientific support for any claims of therapeutic benefit than results that do not incorporate a measure of gingival bleeding.

We support the gingival index of Loe and Silness and its modifications that incorporate a measure of sulcular bleeding because sulcular bleeding is a sensitive clinical measure of gingival inflammation. A periodontal probe inserted only 1-2 mm into a periodontal pocket will provide an indication of sulcular bleeding at a site of measurement. The scoring of bleeding will be evaluated as positive (bleeding) or negative (no bleeding).

PLAQUE

Reports in the current dental literature contain indices and methods for measuring plaque both quantitatively and qualitatively. These methods are sufficiently discriminating to show differences among the variables which affect the development and growth of plaque. Some of these methods use indices which estimate supragingival plaque quantitatively by assessing total tooth area cover, thickness of the plaque in the area measured, or plaque mass (wet or dry weight). Other methods, however, characterize plaque qualitatively by evaluating the microbiological composition and the biological activity of plaque microorganisms. The objective of microbial assessment of plaque is to determine whether there are shifts in the balance of flora which might have an adverse effect on oral tissues, or contribute to the progression of microorganisms in the flora from non-periodontal pathogens to those which are pathogenic. There is also concern that the development of resistant microorganisms does not occur with the use of these products.

Several plaque indices are recognized as reliable for measuring plaque qualitatively by estimating area. These indices score plaque on visually accessible tooth surfaces and can be used for evaluating mechanical anti-plaque procedures such as toothbrushing and flossing, as well as chemotherapeutic anti-plaque agents. The method used should, ideally, be applicable to studies in children and adults. It may be necessary to modify these techniques to suit the study protocol. For example, since plaque will be sampled for microbiological assessment, it may not be feasible to stain plaque before scoring.

One characteristic of all the indices which estimate plaque quantitatively is they are subject to examiner sensitivity. It is recommended that, where possible, the same examiner be trained and used in clinical trials with the same group of patients throughout the study. However, multiple examiners would be acceptable if they are calibrated.

An additional feature of plaque indices which estimate plaque quantitatively is that the indices do not behave in a linear fashion. It is suggested, therefore, that in analyzing data from these indices it is essential to note not only the actual plaque scores, but also the fate of those plaque scores through the course of the study. That is, a record should be made of actual shifts from one score to another through the course of the study.

MICROBIOLOGICAL ASSESSMENT OF SUPRAGINGIVAL PLAQUE

A significant question raised by the committee in evaluating products containing agents which have antimicrobial effects is the effect on oral flora and oral tissues when these products are used. These products should be used only when indicated for the control of plaque and gingivitis. This use could potentially be for periods varying from a few days to months. It is important, therefore, to monitor oral flora and observe soft tissues in patients during the study for the development of candidiasis, oral ulcerations or other manifestations of opportunist microorganisms that proliferate and may lead to secondary mucosal infections.

Microbiological sampling should be incorporated into the design of a study at time intervals which best reflect the targeted use of the product. For example, for conventional antimicrobial agents intended to be used following a dental visit which would traditionally include a prophylaxis it is suggested that sampling be done prior to a prophylaxis to establish a baseline. Sampling would also be done at an intermediate examination period, preferably early in the study, and at the final examination period of six months. If a protocol is designed to test a product to be used for a specific indication where a pre-prophylaxis baseline is not required, it should include appropriate modifications in design. It has also been suggested that consideration be given to including a microbiological assessment of post-treatment plaque in the study design. This would provide information on progression of the flora after the test agent had been discontinued. While this is the information that might be of value in monitoring progress of treatment in an individual patient, and would be of academic interest in the pharmacological study of drug therapies, it is not a requirement for products evaluated by the committee.

It is suggested that subjects should be randomly selected from the study group and several areas (at least 3 to 4) should be sampled in each individual. Areas sampled are left to the discretion of the investigator, but sampling should be done in a manner to which statistical analysis can be applied.

Plaque should be harvested in such a way from the areas chosen for sampling that an objective evaluation of the flora can be made. Methods which require that total plaque be harvested from each area chosen for sampling and counts recorded as either counts per site or counts per milligram of wet plaque weight per site are acceptable as a method of documentation. Results can then be averaged over the sites of investigation for purposes of reporting. Frequencies of isolation of specific organisms at specific levels per site can also be reported.

Resistance of microorganisms can be evaluated by assessing the minimum inhibitory concentration (MIC) of representative mucosal pathogens. These assessments are generally a part of testing during product development, and, where feasible, should be included in the submission to the committee. These assessments can be made before, during and after termination of the study to determine whether differences in the MIC of an antimicrobial chemotherapeutic agent occurs with use.

Secondary mucosal infections are not restricted to the areas of the teeth and gingivae. Therefore screening for opportunistic infections will have to

include clinical examination of the tongue, palate, floor of mouth and cheeks. Any clinical signs of active infections such as candidiasis will have to be recorded and followed by clinical microbiological investigation. Any other symptoms of opportunistic infection such as the burning mouth syndrome will also have to be recorded and investigated clinically.

ESTIMATES OF TOTAL PLAQUE BACTERIA

Plaque samples should be collected using recognized methods and grown both aerobically and anaerobically on a nonselective rich nutrient medium such as blood agar to obtain counts for estimating total bacterial load. Such counting must employ appropriate quantitative plating equipment.

ESTIMATES OF REPRESENTATIVE PLAQUE BACTERIA

Plaque samples should be grown on media selective for appropriate representative groups of microorganisms. The use of dark field or phase contrast microscopy would be an additional method suitable for identifying motile forms such as spirochetes and selemonads. A count and microscopic analysis should be made to estimate plaque content of representative populations of microorganisms by genera and species will depend on the method chose by the investigators. It is suggested that representative populations of these microorganisms be included:

gram positive	gram negative
gram negative enterics	aerobes
spirochetes	anaerobes
pigment-forming bacteroides	rods
yeasts	cocci

Comparisons should be made at the three time intervals for control and test groups. The data should clearly characterize the oral flora in the control group compared with the test group in terms of normal populations identified in supragingival plaque. Microorganisms associated with a healthy gingival condition are predominantly but not exclusively gram positive, predominantly facultative, saccharolytic and nonmotile. It is anticipated that successful long term studies with antimicrobial agents will demonstrate that although a shift or change in the species of these bacteria may occur, a shift to predominantly gram negative, anaerobic, and motile forms should not occur.

Specific microorganisms have been associated with rapidly progressing periodontal diseases such as periodontitis. Therefore, it is essential to demonstrate that these bacteria do not develop supragingivally during the course of a clinical study. Additionally, it is essential that opportunistic organisms such as yeasts and gram negative enteric bacteria do not develop during the course of the study.

TOXICOLOGICAL PROFILES

Information submitted for products containing active chemotherapeutic agents should include assessments of possible toxic effects of the active agent or adverse effects of the product formulation. These assessments should include standard toxicological profiles depending on the particular product. The committee will require that all products submit data on the carcinogenicity and mutagenicity of the product or its active agents. It must be assumed that products submitted to the committee will have met minimum requirements of the Food and Drug Administration for safety.

In addition to standard toxicology profiles, it is suggested that a submission be made of the effect of the product, if any, on taste sensation, staining of oral tissue, or other characteristics that may be unique to the active formulation.

The number of patients dropping out of either the active or the placebo groups must be reported along with their major reasons for dropping out. In this way the likelihood of future adverse reactions can be estimated.

STATISTICAL ANALYSIS AND CONCLUSION

Although the basic location of measurement is the periodontal site on a tooth, the basic unit of statistical analysis and reporting is to be the patient. Presentation of findings is only meaningful if in the comparison of the active versus placebo groups each patient provides only one value per analysis. In this way the bias of inter-patient variation is minimised in any comparison of inter-treatment group differences. Appropriate statistical methods should be applied to permit presentation and comparison of subgroups of the data. The statistical approach should permit unbiased comparison of results for molars versus incisors or any other such subgroups of the data.

Use of the patient as the basic unit of analysis and reporting implies pooling of data only during the process of statistical analysis and not before. The periodontal site will continue to be the location clinical and microbiological measurement. For example, plaque samples collected from individual sites must be analyzed individually because different types of sites will show different results. The guidelines are not to be interpreted as indicating pooling of plaque samples prior to analysis.

Mean values for the clinical measurements for the different treatment groups should be presented along with range and standard deviation and patient numbers. Each patient should contribute one value in the calculation of the overall means. It would be appropriate to break down the data according to tooth type and other criteria. Presentation of actual mean values will permit evaluation of the magnitude of the observed effects.

Statistically significant reductions at the 95% confidence level should be demonstrated for gingivitis and plaque scores where appropriate. Reductions in plaque should be compared with placebo or control treatment rather than baseline scores. Reductions in gingivitis (and plaque) should be demonstrated after six months of use when compared with placebo or control treatment performed for the same length of time.

We have set a clinically acceptable level of control of gingivitis at an average value per patient of 0.75 for the gingival index of Loe and Silness or a clinically equivalent index. This target level may be adjusted when data from further investigations become available. In all cases we will expect to observe a statistically significant reduction of gingivitis to a clinically acceptable level as a result of use of the chemotherapeutic product.

In view of the known effect of the level of mechanical plaque control on the level of effect of chemotherapeutic plaque control, data must be presented to show the level of mechanical plaque control home care in the different treatment and placebo groups.

When data from the intermediate time interval are compared with data at six months, there should be no drop in effectiveness at the six month time period unless the test period is extended sufficiently beyond six months to establish a long-term reduction in gingivitis.

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Q Is Colgate's new tartar-fighting toothpaste more abrasive than regular toothpaste?

A No. Colgate's new tartar-fighting toothpaste is no more abrasive than regular toothpaste and will not remove tartar once it is formed. It will, however, chemically inhibit the formation of new tartar.

Q Can children use Colgate's new tartar-fighting toothpaste?

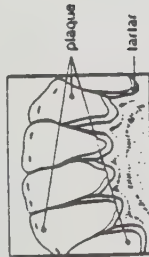
A Yes. Colgate's new tartar-fighting toothpaste's special formulation is suitable for people of all ages. However, since children do not normally form tartar to any great extent, they may prefer to continue using their current fluoride toothpaste.

THE FACTS ABOUT TARTAR

APPENDIX II

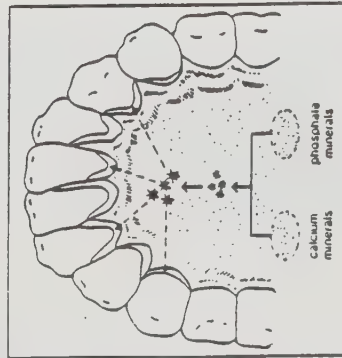
This pamphlet is presented in the
interest of good oral hygiene by
Colgate-Palmolive Canada
Toronto, Canada M4M 1N7

Q What is the difference between tartar and plaque?



A Plaque is a soft, invisible bacterial film that builds up on teeth. It can be removed by flossing and proper brushing with any toothpaste. Tartar, however, is different, and forms independently of plaque. Tartar is an ugly, hard, crystalline deposit that is visible on the tooth surface. It is off-white to yellow in colour, and once formed, can only be removed by a professional dental cleaning.

Q How does tartar form?



A Tartar forms when the calcium and phosphate minerals in saliva combine to produce microscopic crystals. These crystals grow larger and eventually adhere to the tooth surface, collecting at the gumline.

Q How can I control tartar most effectively?

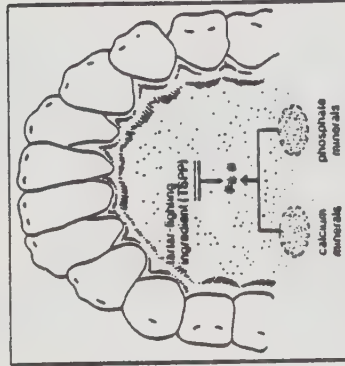
A 1. Start with a professional dental cleaning.

2. Brush regularly with a toothpaste like Colgate's new tartar-fighting formula to reduce tartar build-up.

3. Floss daily.

4. Visit your dentist regularly for a check-up and dental cleaning.

Q How does Colgate's new tartar-fighting toothpaste work?



A Colgate's new tartar-fighting toothpaste contains a special ingredient called tetrasodium pyrophosphate (TSPP). TSPP helps prevent the calcium phosphate crystals in saliva from growing large enough to form tartar, thereby reducing tartar build-up between dental cleanings by almost 50%.

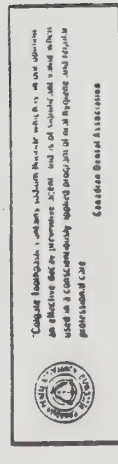
Q Can ordinary fluoride toothpastes control tartar just as well as Colgate's new tartar-fighting toothpaste?

A No. Ordinary fluoride toothpastes do not affect the formation of tartar. However, Colgate's new tartar-fighting toothpaste's special formulation has been clinically proven to reduce tartar build-up on teeth between dental cleanings.

Q Will regular use of Colgate's new tartar-fighting toothpaste mean that I don't need to visit my dentist or hygienist as often?

A No. Although Colgate's new tartar-fighting toothpaste helps reduce the build-up of tartar above the gumline between dental cleanings, any newly formed tartar should be removed on a regular basis by your dentist or hygienist.

Q Will Colgate's new tartar-fighting toothpaste still protect me against tooth decay like my old toothpaste?



A Yes. Colgate's new tartar-fighting toothpaste contains sodium fluoride which is recognized by the Canadian Dental Association for its anti-cavity effectiveness.

EDITORIAL BOARD

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. John Hardie, Chairman, Ontario
Dr. A.D. Sparrow, Alberta
Dr. R.S. Turnbull, Ontario
Dr. P.C. Desautels, Quebec

1. Board Meeting

A meeting of the Editorial Board was held on October 26, 1986. In addition to the Board members, the following were present:

Ms. C. Hackland, Journal Editor, CDA
Mr. C. Metcalfe, Journal Associate Editor, CDA
Ms. A. Bisson, Journal Production Assistant, CDA
Ms. A. Spencer, Journal Advertising Manager, CDA

ITEMS FOR INFORMATION NOT REQUIRING BOARD ACTION

2. Membership

Use of the Journal as a membership vehicle was discussed. The Editorial Board passed a resolution indicating: "That it be brought to the attention of the Membership Committee of CDA that an opportunity exists to make use of the Journal to encourage, enlist and suggest membership status to non-members who are now to receive the Journal as a complimentary or courtesy basis; and that the method be decided by the two committees after due consideration."

.../2

EDITORIAL BOARD

3. Status Reports

Following discussion on status reports, the Board passed resolutions recommending that both the Council on Dental Materials and Devices and the Committee on Consumer Product Recognition prepare for publication status reports/articles on cosmetic dentistry and toothpastes/mouthwashes, respectively. In addition, the Editorial Board is interested in any status reports on either dental materials and devices or product recognition which the Council or Committee may wish to publish in the Journal of the Canadian Dental Association.

4. Editorial Board Members

Upon the recommendation of the Editorial Board, Dr. J. Robertson, President of CDA, has appointed Dr. P.R. Crawford (Manitoba) and Dr. R.V. Glover (Ontario) to fill vacancies on the Editorial Board.

5. Journal Contents

The Editor was encouraged to:

- (i) Publish only summaries or conclusions of CDA sponsored seminars or symposia.
- (ii) Consider a standard design for the front cover of the Journal.
- (iii) Investigate alternative methods of producing and printing the Journal.
- (iv) Make appropriate use of colour screens, and if possible, colour photographs.
- (v) Promote the classified advertisements.
- (vi) Insert in each issue abstracts or brief descriptions of articles and features appearing in future issues.

6. Scientific Articles

The number of English Scientific articles submitted during 1986 was 47, the same for the previous year. The lead time at 9 - 12 months is considered satisfactory. The number of French articles has increased from 2 in 1985 to 5 in 1986 and with full circulation, a further increase is anticipated.

EDITORIAL BOARD

- 3 -

7. Features Survey

The survey conducted at the CDA Convention in Halifax produced only 8 responses and therefore no significance could be given to the results.

Respectfully submitted,

John Hardie, B.D.S., M.Sc., FRCD(C)
Chairman - Editorial Board

ADOPTION OF REPORT

The Board of Governors accepts the report of the Editorial Board with appreciation.

GOVERNMENT RELATIONS COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS MEETING

Items for Information not Requiring Board Action

The Government Relations activity of the CDA has been interesting to observe over the last eighteen months. Primarily, we have remained active by virtue of the on-going level of activity, documented herein, at the staff level. Our Executive Director in particular maintains contact on our behalf with a number of individuals and agencies. We also have initiated a number of activities that have been popular and successful.

APPENDIX I

Coincident with the Interim Board of April, 1986, we began a series of Government Relations sponsored dinners for our Governors. These have been well received, and have offered an opportunity to not only increase the profile of CDA, but to dialogue on a frank and open basis with key government representatives. Although the opportunity for exchange will obviously be more limited, we will be honoured to have the Minister of Health, the Honourable Jake Epp, address our April, 1987 Interim Board Meeting.

Two years ago, the Council on Information Services held a reception to launch the original Dental Awareness Program. Last year, a very successful follow-up "kicked-off" year two of the Dental Awareness Program, as well as Dental Health Month 1986. This tradition will continue in 1987, since it serves not only Dental Awareness and Dental Health Month but should become an integral part of our Government Relations strategy on an annual basis. It provides an opportunity to host a number of government individuals and agencies on a social/professional basis and, as an approach, has been well received. It should remain as a corner stone of our Dental Health Month, Awareness and Government Relations activity.

Relations with Medical Services Branch have been excellent, and an Ad Hoc Committee is currently negotiating a number of issues with them. Progress has been good and positive results are expected. The Chairman of this activity is Dr. Bradley Holmes. A report is appended, and our excellent relationship with the Assistant Deputy Minister in this area is the basis for the rapport that has developed between CDA and Medical Services Branch - Health & Welfare Canada.

APPENDIX II

GOVERNMENT RELATIONS COMMITTEE

Our Taxation Committee is relentless in its efforts to obtain equity and fairness on a number of issues, on behalf of Canadian dentists. The launching of Taxation Seminars is another effort to provide a tangible quality membership service to dentists, and promote the value of Canadian Dental Association membership in general.

The Government Relations Committee had a meeting with the Executive Director of the Canadian Medical Association in October, 1986, prior to the Management Committee meeting at Mont Ste Marie. Dr. Léo-Paul Landry is new in his role as Executive Director at CMA, and we had a frank discussion of some of the problems facing our organizations. We appear to face a common problem in the area of resource availability, when it comes to planning strategies for the future. Both of our professions face challenges from special interest groups that have spent significant time and money advancing their causes. Our own future planning remains inadequate in relation to these efforts, and we must be more vigilant when it comes to the future of our profession. We feel that our organizations will relate on a most cooperative basis in the future, and Dr. Landry has offered the expertise and resources of the CMA whenever we want to discuss issues of mutual concern.

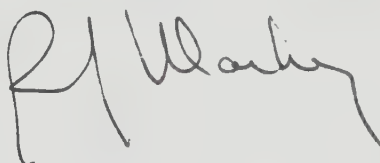
The next few months will see a continuation of activity in the area of Medical Services, Taxation, Dental Health Month, and on-going in-house government relations operations.

In addition, we will meet with the Health Promotion Branch of Health and Welfare Canada to gain more insight into the new Health Promotion Strategy that has been tabled by Minister Epp in the last few months. Dentistry badly needs information in several vital areas, if it is to continue its efforts in prevention and the promotion of optimal dental health for all Canadians. If funding for projects is available, we want to know how it is accessed. The proposals of the Minister with respect to Health Promotion may form the most significant strategy to come out of the Health Ministry in years. If carried forward as Government policy, the implications are widespread. We need to understand more about this strategy. Dentistry has an enviable track record in prevention; it has "put its money where its mouth is" in the promotion of the consumers' dental health knowledge. Our knowledge bank, when it comes to demographics, geriatric needs, and adult dental health needs is limited. We need a firmer grasp on the future direction of national health care policy, and should take an aggressive posture, when it comes to the importance of dental health in the overall health picture for Canadians.

GOVERNMENT RELATIONS COMMITTEE

The Management Committee and Executive Council have supported a motion that the Government Relations Committee become a standing committee of the Executive Council, with more independent make-up for the sake of continuity. By the September, 1987 Board of Governors meeting, our goal is to review activity in Government Relations and firm up the committee structure in this area. Discussions are underway and recommendations will be in place by September, 1987.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "R. Markey", written in a cursive style.

Ron J. Markey, Chairman
Government Relations Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Government Relations Committee with appreciation.

APPENDIX I

GOVERNMENT RELATIONS

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

SUMMARY OF ON-GOING ACTIVITIES

Schedule of activities and meetings for the period June 1986 - January 1987

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson Crawford Robertson Holmes	86-06-26	HWC	R. Laine H. Wilson W. Ross	RD Atlantic Consultant Consultant	Interview with Dental Services Review Team
Neilson	86-07-08	HWC	D. Nicholson	ADM-MSB	Meeting to discuss current issues MSB/CDA
Neilson	86-07-11	HWC	R. Laframboise	ADM-Corporate	Discussion of CDA/ODA/HWC contracting relationships
Neilson	86-07-14	EXT. AFF.	R. Cleminson	DG Disarmament	Discussion of protocols related to International Congresses

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson	86-08-13	HWC	W. Bedford	Sr. Dental Consultant	Current Issues Discussion: - Research Funding - PRUC
Neilson Holmes	86-09-19	HWC	D. Nicholson J. Gillies	ADM-MSB ED-ODA	Dental Services Review Discussion
Neilson	86-09-22	AGR	P. Connell	DM-AGR	Reception
Neilson	86-09-25	Treasury Board Secretariat	L. Tenace	DEP. SECY. STAFF RELATIONS	Address to staff relations officers of Government
Neilson	86-09-26	PSC	H. Labelle	Chairman	Luncheon Meeting - Environmental changes - Senior Service
Neilson	86-09-29	EXT. AFF.	G. Pardy G. Wilson	Dir. Phillipines Desk Asst-Dir.	Protocol & Registration Requirements - FDI - Manila

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson	86-09-29	RC-C&E	B. Oxley	Tax Interpretations Officer	Arrangements for address by RD, Excise, Toronto, to DIAC
Neilson	86-09-31	EXT. AFF.	G. Pardy Mr. Longmuir	Dir. Phil. Desk Assistant	- Reception at Embassy during FDI 86 - Planning - Reception FDI 87
Neilson	86-10-16	HWC	D. Michaud	Special Assist. to Minister	Participation of Minister at BOG - April 87
Neilson Robertson Holmes Markey	86-10-22	HWC	D. Nicholson W. Bedford	ADM-MSB Sr. Dental Consultant	Review of Dental Services Review Team Report
Neilson	86-11-13	CEOs of National Health Org.	G. Rodger J. Martin	ED - CNA ED - CHA CPHA CCCH VON CLA	Issue Exchange
Neilson	86-11-20	HWC	R. Laframboise	ADM - CORPORATE	Discussion of Legal Questions on Contracting

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson Holmes Thordarson	86-11-27	HWC	D. Nicholson D. Obonsawin J. Hucker W. Bedford	ADM-MSB DGO-MSB Sr. Dental Consultant	Dental Services Review Meeting
Hicks	86-12-05	RC-TAX	G. Venner K. Warren	DG-Audit Programs Special Audits	"Personal Services Business Definition" Meeting
Hicks Little	86-12-05	RC-TAX	G. Murray J. Lynn	Dir. Charity Division Section Head	Discussion of proposed Canadian Dental Foundation
Neilson	86-12-22	PMO	Nicole Leboeuf	Special Ass't Prime Min.'s Office	CDA/ODQ Convention Speaker
Neilson	86-12-23	HWC	W. Bedford	Sr. Dental Consultant	-Health Strategies - Minutes 11/27 - Mozambique
Neilson	87-01-08	DVA	J. Tsafaroff	Sr. Dentist	DVA - Denturist Relationship

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson	87-01-08	TBS/OCG	G. Duclos	Deputy Controller General	Govt. Controller Network
Neilson	87-01-20	Revenue Canada - Taxation	H. Rogers	Dep.Minister	CDA/RC-Tax Working Relationship
Neilson	87-01-21	RC-Cust. DND RC-Cust. CIDA CIDA DRIE HWC CEIC	Huneault, L Lindley, D. Cox, K. Bassett, C. Zukowsky, J. Wilkins, J. Laframboise, R. Cyr, J.	DM ADM DG Vice-Pres. DG FEDC ADM ADM	Networking



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

December 8, 1986

Mr. David Nicholson, Assistant Deputy Minister
Medical Services Branch
Health and Welfare Canada
Room 1940 - Jeanne Mance Building
Tunney's Pasture
OTTAWA (Ontario)
K1A 0L3

Dear Mr. *David* Nicholson:

I felt that it would be helpful if I forwarded you our version of the discussion, commitments, and decisions taken at the November 27 meeting. By the way, the manner in which you and your people ensured a full and clear hearing of the issues at hand was much appreciated.

The following are the principal points as seen by the CDA side:

L DENTAL CLAIMS PROCESSING SYSTEM

- The Department will seek bids on the design and implementation of the new automated dental claim processing system.
- It had been intended that this system go to tender by November 1. Slippage has occurred, and the present projection for tender calls is end November, 1986.
- The target date for implementation is April 1, 1987.
- Implementation will be carried out on a staged pilot basis, with full implementation scheduled for April 1, 1988.
- The system is intended to be a "central source" system.
- The system will seek compatibility with the Schedule of Dental Services.

.../2

- Discussion took place on the question on a standard dental claim form. Two principal differences were noted between the CDA Standard Dental Claim Form and the MSB Claim Form. These are:
 1. MSB requirements for patient information such as band number and registration number of individuals.
 2. The MSB claims process is not automated; procedure codes emanating from the CDA Claim Form pose difficulties for MSB which handles claims on a "hand-sort" basis.

2. NEW SCHEDULE OF DENTAL SERVICES

- There is general acceptance of the new schedule.
- This new schedule was distributed to regional directors at the beginning of October, 1986. There is virtually complete consensus on Section A, some reservations remain with regard to Sections B and C.
- Drs. Bedford and Holmes are to consult on these differences, for the purpose of ensuring that CDA views are on record.

3. IMPEDIMENTS TO AN EQUITABLE FEE STRUCTURE

- CDA raised the question: "Why not 100 % of the provincial fee schedule?". The simple business answer would include provision for a "volume discount".
- Discussion ensued on the disadvantages to an automated system of having a variety of fee arrangements between MSB and individual provincial dental corporations.
- The concept of a uniform percentage payment of fee schedules across the country, in terms of its advantage to an automated claims processing system was raised. It was agreed that MSB would undertake to prepare and study cost comparison figures to the Crown, which would result from a uniform percentage payment of fee schedules at 85 %, 90 %, and 95 % levels.

4. DENTAL THERAPISTS/SCHOOL AND PROGRAM

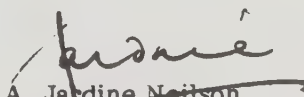
- CDA's basic position was put forth, which allows for the use of dental therapists in a treatment mode north of 60 degrees latitude, and in a prevention mode south of 60 degrees. Also, CDA's opposition to the use of dental therapists in treatment modes in areas where there is no shortage of dentists was stated. It was generally agreed that it would be impossible to hew rigidly to the use of 60 degrees latitude; there are exceptions related to population concentrations which would, of necessity, prevail.

- The suggestion of combining the school of dental therapy with the Wascana Centre was also discussed. It was agreed that the method and location of producing therapists or hygienists was not a crucial issue; they can be made under contract, or bought on the open market. What is important is their availability to meet client needs.
- CDA's position on supplying services to remote areas is: "You tell us where they are needed and we will find the dentists". MSB's position was stated succinctly as: "We are for anything that will improve the service to our clientele."
- MSB spoke of the Native Health Career Program, and sought CDA's cooperation in assisting MSB in increasing the number of native people entering the various health professions. CDA agreed to assist as requested.
- It was also agreed that the feasibility of operating three pilot projects be examined, to test treatment models involving dentists/hygienists, dentists/therapists, and dentists/Wascana graduates. MSB, in conjunction with CDA, will develop the pilot project design.
- The Advisory Board to the School of Dental Therapy was also discussed. It was agreed that this advisory body be revived, and an early meeting called by the Chair.

I think that the above covers the key points of our deliberations, but would be pleased if you would add or modify any of the above, and forward CDA your agreed-upon copy.

Once again, many thanks for your hospitality and cooperation. The relationship is a productive one.

Sincerely yours,


A. Jardine Neilson
Executive Director

/ml

MANAGEMENT

REPORT TO THE 1987 INTERIM MEETING CDA BOARD OF GOVERNORS

Members: Dr. John R. Robertson, Summerside, Chairman
Dr. Ron J Markey, Vancouver
Dr. Bradley W. Holmes, Kenora

1. Committee Meetings

Since the 1986 Annual Board of Governors meeting, the Management Committee has met twice - October 29-30, 1986 and February 11-12, 1987.

ITEMS REQUIRING BOARD ACTION

2. Audited Financial Statement - Canadian Dental Association

APPENDIX A

The Audited Financial Statement for the Canadian Dental Association was reviewed and explanatory notes are included for information.

RESOLVED:

87.31 THAT the audited statement for the Canadian Dental Association for the year ending December 31, 1986 be approved.

ADOPTED

3. Audited Financial Statement - Canadian Dental Research Foundation

APPENDIX A

Management Committee reviewed the Audited Financial Statement for the Canadian Dental Research Foundation.

RESOLVED:

87.32 THAT the audited financial statement for the Canadian Dental Research Foundation for the year ending December 31, 1986 be approved.

ADOPTED

MANAGEMENT

4. Revised 1987 Budget

APPENDIX B

At the 1986 Planning Session, Executive Council reviewed current priorities and examined areas requiring heightened emphasis.

Alternate Delivery Systems, Professional Resource Utilization, Membership Strategies, Dental Awareness, Accreditation, Government Relations, and the funding of an appropriate level of staff support for CDA programs were identified as priorities. Newly identified priorities necessitated adjustment to the 1987 budget. Executive Council directed that the 1987 budget be reviewed by senior staff in consultation with Council/Committee Chairmen and Executive Liaisons, to identify areas of potential savings through reduced expenses, and postponement/cancellation of planned meetings.

The budget review process resulted in an adjusted budget which more accurately reflected 1987 requirements, but did not free up funds for new priorities. Further reductions to 1987 expenditures are addressed in motions which follow later in this report. The revised 1987 budget reflects these reductions, and a further allocation of funds to individual priority items.

RESOLVED:

87.33 THAT the revised 1987 budget be approved.

ADOPTED

5. Review of Per Diems/Convention Expenses - Executive Council

Management Committee reviewed the present policy relating to the payment of convention registration packages and per diems for Executive Council Members during conventions.

Present policy provides for free convention packages for all Executive Council Members, full-day per diems for Management Committee and half day per diems for Executive Council, for the duration of the Convention.

RESOLVED:

87.34 THAT the policy on the payment of convention packages for Executive Council members continue as at present with the following exception: in the event of a conjoint convention not held in conjunction with a Board meeting, that convention

MANAGEMENT

packages be provided only to members of the Management Committee, and the Executive Council member from the province in question.

ADOPTED

RESOLVED:

- 87.35 THAT Executive Council members receive per diems during Conventions only for time spent on officially assigned CDA business. Full day per diems will be paid for full day functions - half-day per diems for half-day functions. Management Committee will continue to receive full day per diems for the duration of the convention.

ADOPTED

6. 1987 Increases in Per Diem/Honoraria Rate

Present policy calls for a CPI increase in per diems and honoraria as of January 1, 1987 - CPI being approximately 4%. Due to the current budgetary constraints, and the required commitment to program priorities:

RESOLVED:

- 87.36 THAT there be no increase in the current rate of per diems for 1987.

ADOPTED

RESOLVED:

- 87.37 THAT there be no increase in the current rate in honoraria for 1987.

ADOPTED

NOTE: The CPI increase in per diems and honoraria will be reviewed on an annual basis.

7. Funding Policy - Annual Meeting Presidents and Chief Executive Officers

CDA expenditures toward this meeting were examined in conjunction with the 1987 budget review. CDA policy indicates that funding is available for two representatives from each corporate member. Management reviewed this policy in light of the fact that the meeting is held in conjunction with the Annual Meeting of the Board of Governors. Corporate members would normally finance their Presidents and CEO's at a Board Meeting. CDA is willing to provide organization, administration, and the costs of meeting facilities, one day accommodation and related meals. It was felt that corporate bodies should not submit expenses for air fare which they would have to pay if the President's and CEO's meeting were not held.

RESOLVED:

87.38 THAT expenses be paid for one day's accommodation, as well as meals and incidental expenses related to the day of the meeting. No travel costs will be paid.

DEFEATED

DIRECTION: The above motion was referred to Management Committee for reevaluation and further recommendation.

8. Unaccountable Expenses - Executive Council

In 1985, the Board approved a recommendation of the Ad Hoc Committee on Per Diems that Executive Council members be paid a stipend of \$1,000.00 per year to cover incidental unclaimed expenses. Management Committee reviewed this item, noting that all possible expenses, including a daily claim for incidental expenses may be claimed.

RESOLVED:

87.39 THAT the annual stipend for unaccountable expenses for Executive Council be discontinued effective in 1987.

ADOPTED

MANAGEMENT

9. 1988 Membership Fee Increase

At the 1987 Annual Meeting, Governors approved a 3.8% - \$10.00 increase in the fee for active members effective January 1, 1988, and a proportionate increase in all other membership categories except that of corporate members. This resulted in an active membership fee of \$270.00 effective January 1, 1988.

At that time notice was given that a further 1988 fee increase recommendation would be presented at the 1987 Interim Meeting if program and/or operation priorities so indicate. Priorities established by the Executive Council for 1987 and the re-examination of the 1987 budget indicate a further increase is required if a balanced budget is an objective for 1988.

RESOLVED:

87.40 THAT CDA active membership fees for 1988 be increased an additional \$20 - 7.7% for a total 1988 fee of \$290.00. All other fees, excluding corporate fees, will be increased proportionately.

ADOPTED

ITEMS FOR INFORMATION NOT REQUIRING BOARD ACTION

10. Category of Air Travel

The current CDA expense policies provide for full fare economy class air travel. Management Committee reviewed this policy in light of potential for considerable savings through use of excursion and other reduced fares. The expense policy will be revised to reflect that as a general rule, reduced air fares be utilized as a matter of course for scheduled meetings of the CDA.

11. Mortgage on the CDA Building

The mortgage with the Toronto-Dominion Bank is a floating rate promissory note in the amount of \$543,000.00.

MANAGEMENT

Security for this loan is a collateral first mortgage on 1815 Alta Vista Drive. The mortgage bears interest at the Bank's Prime Rate, calculated monthly. The monthly loan payments are broken down into principal, which is a fixed amount of \$2,262.50, and interest, which varies at approximately \$4,700.00.

The Canadian Dental Association has the privilege of prepaying the loan in full or in part without interest penalty. The present outstanding balance as at December 31, 1986 is \$495,487.50. Maturity date is March 1, 2005.

12. Property Management

The CDA building is fully occupied with the exception of a limited amount of space available to specialty sections and affiliated dental organizations. The CFDE is now housed in the CDA building, and ACFD, CAO, and CAOMS have expressed an interest.

A computerized control unit for the existing heating system has been purchased at a cost of \$18,500 in order to effect cost-savings, and stability.

13. Medline Services

A review of the utilization of medline services indicates the necessity to establish utilization fees for both members and non-members. Fee structures will be developed, highlighting medline as a membership service.

14. Helen Margaret Langstaff - Bequest to CDA

The Canadian Dental Association was named as a major beneficiary in the will of the late Helen Margaret Langstaff. Daughter of Dr. Sydney Wood Bradley, Mrs. Langstaff directed that 40% of her estate be paid to the CDA "to be used for the purposes of the Sydney Wood Bradley Memorial Library". A major distribution of monies from the estate has recently been completed, and CDA has received the sum of \$1,360,000.00.

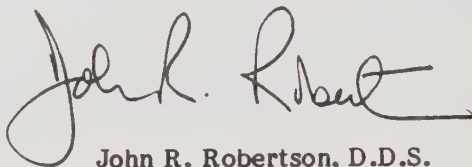
MANAGEMENT

The CDA is holding these funds in Trust pending the establishment of a "Canadian Dental Foundation". Information concerning the establishment of the Foundation is contained in the report of the Taxation Committee. The funds have earned approximately \$23,000 in interest up to December 31, 1986.

15. Payment of Fees to CDA

Corporate bodies have been requested to provide information on the payment of fees to CDA, including details of provincial legislation which impacts on fee payment. This information has been reviewed in relation to requirements of the CDA Constitution and By-Laws. The Membership Committee report contains recommendations in this regard.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "John R. Robertson". The signature is fluid and cursive, with a long horizontal stroke at the end.

John R. Robertson, D.D.S.
Chairman - Management Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Management Committee with appreciation.

The Board of Governors expresses its appreciation to the Firm McCay, Duff and Co., and more specifically to Mr. Tom Howarth, for their numerous services rendered to the CDA.

CANADIAN DENTAL ASSOCIATION

FINANCIAL STATEMENTS

DECEMBER 31, 1986

CANADIAN DENTAL ASSOCIATION
INDEX TO FINANCIAL STATEMENTS
DECEMBER 31, 1986

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2	Balance Sheet
3	Statement of Equity
4	Statement of Revenue and Expenses
5	Library Trust Fund Statement of Revenue and Expenses and Equity
6	The Grieve Memorial Lectureship Fund Statement of Revenue and Expenses and Equity
7 & 8	Notes to Financial Statements
9	Schedule of Revenue Membership Fees Accreditation Education Communication Journal Other Revenue
10	Schedule of Expenses Executive Administration
11	Schedule of Expenses Accreditation Education Journal
	The Canadian Dental Research Foundation
12	Auditors' Report
13	Balance Sheet
14	Statement of Revenue and Expense
15	Notes to Financial Statements

Mc CAY. DUFF & COMPANY

CHARTERED ACCOUNTANTS

Page 1.

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.A.D.M.I.N., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.
G. WARREN TRICKEY, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

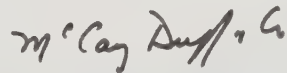
330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

AUDITORS' REPORT

To the Members,
Canadian Dental Association.

We have examined the balance sheet of the Canadian Dental Association as at December 31, 1986 and the statements of equity, revenue and expenses and revenue and expenses and equity for the Library Trust Fund and the Grieve Memorial Lectureship Fund for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Association as at December 31, 1986 and the results of its operations for the year then ended in accordance with accounting policies as described in note 1, applied on a basis consistent with that of the preceding year.



Chartered Accountants.

Ottawa, Ontario,
January 22, 1987.

Supplementary notes to the 1986 audited financial statements.

BALANCE SHEET (page 2)

Cash, Deposit Certificates and Differed Revenue

Cash and certificate holdings were markedly lower than last year because the membership campaign was initiated later in the year. This delayed the inflow of 1987 funds in 1986. Coincidentally the deferred revenue is also lower as the monies that CDA receives in the current year that apply to the following year, must be accrued in deferred revenue. The delayed start in the campaign simply meant that the majority of the funds for the 1987 membership year will be received in 1987.

Accounts Receivable

Receivables were down somewhat in 1986 due to a couple of factors. First, some \$60,000 due from the estate of Dr. Gollop was set up as a receivable in 1985, inflating the balance that year; and secondly, tighter controls have been implemented on the collection of outstanding receivables.

Pre-Paid Expenses

The lower pre-paid expense amount reflects an internal accounting decision to record expenses as incurred rather than postponing the expense to a future date.

Accounts Payable

As with accounts receivable, tighter internal control on payables has resulted in a lower figure.

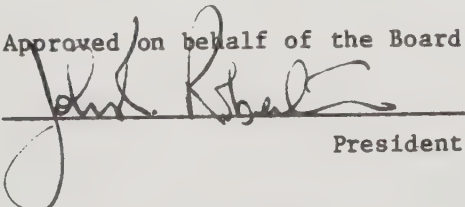
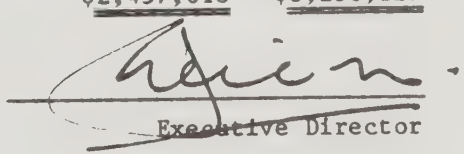
Surplus

The lower surplus figure reflects the loss or deficit that incurred in 1985. This is more clearly shown on the next page.

CANADIAN DENTAL ASSOCIATION

BALANCE SHEET

AS AT DECEMBER 31, 1986

	ASSETS	1986	1985
CURRENT			
Cash		\$ 417,179	\$ 778,036
Cash - Building Contingency Fund		2,674	25,445
Deposit certificate		495,390	750,000
Accounts receivable		53,095	150,769
Inventory (note 1)		41,210	49,457
Prepaid expenses		23,152	64,006
		<u>1,032,700</u>	<u>1,817,713</u>
FIXED (notes 1 and 2)		<u>1,369,829</u>	<u>1,379,134</u>
		<u>2,402,529</u>	<u>3,196,847</u>
	TRUST ASSETS		
Cash		46,910	52,703
Accounts receivable		302	1,276
Prepaid expenses		7,876	5,300
Library books and furniture (at nominal value)		<u>1</u>	<u>1</u>
		<u>55,089</u>	<u>59,280</u>
		<u>\$2,457,618</u>	<u>\$3,256,127</u>
	LIABILITIES		
CURRENT			
Accounts payable		\$ 95,656	\$ 147,095
Deferred revenue		284,912	696,640
Current portion of long term debt		27,150	27,150
		<u>407,718</u>	<u>870,885</u>
LONG-TERM DEBT (note 3)		<u>468,337</u>	<u>495,487</u>
		<u>876,055</u>	<u>1,366,372</u>
	EQUITY		
SURPLUS		652,132	973,978
EQUITY IN FIXED ASSETS (note 4)		<u>874,342</u>	<u>856,497</u>
		<u>1,526,474</u>	<u>1,830,475</u>
		<u>2,402,529</u>	<u>3,196,847</u>
	TRUST EQUITY		
Library Trust Fund		48,242	51,533
The Grieve Memorial Lectureship Fund		6,847	7,747
		<u>55,089</u>	<u>59,280</u>
		<u>\$2,457,618</u>	<u>\$3,256,127</u>
Approved on behalf of the Board:			
	President		Executive Director

STATEMENT OF EQUITY (page 3)

The statement of equity more clearly shows the impact of the deficit.

**The \$700,000 showing as equity basically represents liquid assets such as cash.
The equity in fixed assets represents the current book value of the building and
the office information system.**

CANADIAN DENTAL ASSOCIATION
STATEMENT OF EQUITY
FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>	<u>1985</u>
SURPLUS		
BALANCE - BEGINNING OF YEAR	\$973,978	\$1,141,479
Excess of revenue over expenses (expenses over revenue) for the year	(304,001)	(311,594)
Transfer from (to) equity in fixed assets	(17,845)	153,093
Transfer of bequest to Canadian Dental Research Foundation	<u>-</u>	(<u>9,000</u>)
BALANCE - END OF YEAR	<u>\$652,132</u>	<u>\$ 973,978</u>
EQUITY IN FIXED ASSETS		
BALANCE - BEGINNING OF YEAR	\$856,497	\$1,009,590
Transfer from (to) surplus	<u>17,845</u>	(<u>153,093</u>)
BALANCE - END OF YEAR	<u>\$874,342</u>	<u>\$ 856,497</u>

STATEMENT OF REVENUE AND EXPENSES (page 4)

This statement summarizes the financial activity of the association for the year. Each of the items is presented in more detail later in the financial statements. Consequently, the only item to highlight is the actual deficit position of CDA in 1986. The deficit of 304 is significantly lower than the budgeted deficit of \$386,000.

The smaller deficit is due to a number of factors. These are addressed in more detail later in this report.

CANADIAN DENTAL ASSOCIATION
STATEMENT OF REVENUE AND EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>		<u>1985</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
REVENUE			
Membership fees (page 9)	\$2,071,369	\$2,084,419	\$1,994,451
Accreditation (page 9)	110,375	112,969	102,973
Education (page 9)	155,000	199,672	158,661
Communications (page 9)	122,120	395,120	63,670
Journal (page 9)	451,000	392,599	402,492
Other (page 9)	<u>274,282</u>	<u>273,328</u>	<u>414,604</u>
	3,184,146	3,458,107	3,136,851
EXPENSES			
Executive (page 10)	742,300	803,200	701,777
Administration (page 10)	997,167	929,237	1,215,150
Accreditation (page 11)	351,216	309,100	229,600
Education (page 11)	850,247	1,108,953	743,133
Journal (page 11)	<u>629,192</u>	<u>611,618</u>	<u>558,785</u>
	<u>3,570,122</u>	<u>3,762,108</u>	<u>3,448,445</u>
EXCESS OF REVENUE OVER EXPENSES			
(EXPENSES OVER REVENUE) FOR			
THE YEAR	(\$ <u>385,976</u>)	(\$ <u>304,001</u>)	(\$ <u>311,594</u>)

STATEMENT OF REVENUE AND EXPENSES AND EQUITY (page 5)

The financial operations of the library trust fund in 1986 where similar to the previous year. They do however show some increased activity.

It should be pointed out that the equity of the library trust fund continues to decline.

CANADIAN DENTAL ASSOCIATION
LIBRARY TRUST FUND
STATEMENT OF REVENUE AND EXPENSES AND EQUITY
FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>	<u>1985</u>
REVENUE		
Interest	\$ 3,484	\$ 3,662
Donations	<u>4,444</u>	<u>2,011</u>
	7,928	5,673
EXPENSES		
Books	2,514	1,378
Miscellaneous	330	214
Subscriptions	<u>8,375</u>	<u>7,512</u>
	<u>11,219</u>	<u>9,104</u>
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE) FOR THE YEAR	(3,291)	(3,431)
Equity - beginning of year	<u>51,533</u>	<u>54,964</u>
EQUITY - END OF YEAR	<u>\$48,242</u>	<u>\$51,533</u>

STATEMENT OF REVENUE AND EXPENSES AND EQUITY (page 6)

Likewise, the financial operators of the Grieve memorial fund are similar to previous years. It should be pointed out, however, that the awards shown in 1986 cover a two year period.

CANADIAN DENTAL ASSOCIATION
THE GRIEVE MEMORIAL LECTURESHIP FUND
STATEMENT OF REVENUE AND EXPENSES AND EQUITY
FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>	<u>1985</u>
REVENUE		
Interest	\$ 560	\$ 545
EXPENSES		
Awards	<u>1,460</u>	<u>-</u>
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE) FOR THE YEAR	(900)	545
Equity - beginning of year	<u>7,747</u>	<u>7,202</u>
EQUITY - END OF YEAR	<u>\$6,847</u>	<u>\$7,747</u>

NOTES TO FINANCIAL STATEMENTS (page 7 & 8)

The notes to the financial statements are commentary provide by the auditors to explain variances and methodology used in arriving at the financial statements.

CANADIAN DENTAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS

Page 7.

DECEMBER 31, 1986

1. SIGNIFICANT ACCOUNTING POLICIES

(a) Revenue and Expenses

Revenue and expenses are recognized on the accrual basis.

(b) Inventory

Inventory is stated at the lower of cost and net realizable value.

(c) Depreciation

Furniture and equipment purchased subsequent to January 1, 1979 is expensed when acquired. Purchases prior to this date have been fully depreciated.

Depreciation is provided on the straight line basis as follows:

Building	- 40 years
Building improvements	- 5 years
Data processing equipment	- 5 years

2. FIXED ASSETS

	1986			1985
	Cost	Accumulated Depreciation	Net	Net
Land	\$ 82,915	\$ -	\$ 82,915	\$ 82,915
Building	1,543,034	384,189	1,158,845	1,198,092
Building improvements	159,105	88,499	70,606	32,747
Furniture and equipment	75,769	75,768	1	1
Data processing equipment	125,927	81,003	44,922	52,839
Chain of office	12,540	-	12,540	12,540
	<u>\$1,999,290</u>	<u>\$629,459</u>	<u>\$1,369,829</u>	<u>\$1,379,134</u>

3. LONG-TERM DEBT

	1986	1985
Mortgage	\$ 495,487	\$ 522,637
Current portion	27,150	27,150
	<u>\$ 468,337</u>	<u>\$ 495,487</u>

The mortgage on the building with Toronto Dominion Bank bears interest at bank prime rate and is repayable in monthly instalments of \$2,262 plus interest, maturing March, 2005.

CANADIAN DENTAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS

Page 8.

DECEMBER 31, 1986

4. EQUITY IN FIXED ASSETS

	<u>1986</u>	<u>1985</u>
Balance - beginning of year	\$856,497	\$1,009,590
Additions to fixed assets	64,115	43,217
Mortgage reduction (increase)	27,150 (	118,250)
Depreciation	(73,420)(	78,060)
	<u>17,845 (</u>	<u>153,093)</u>
Balance - end of year	<u>\$874,342</u>	<u>\$ 856,497</u>

5. DENTAL AWARENESS PROGRAM

The budget for D.A.P. revenue was forecast net of the applicable expenses, however the actual figures report all revenues received, including receipts for promotional materials and corporate sponsorships. The expense portion under Education - Information Services includes Council expenses and the entire Dental Awareness Program costs. These costs include program development expenses in addition to the consulting services provided by Manifest Communications.

6. TRUST ACCOUNT

The Association is holding funds in trust for a Canadian Dental foundation, to be incorporated in 1987. In October of 1986 a bequest of \$1,360,000 was received for the purposes of the Sydney Wood Bradley Memorial Library. The funds have earned approximately \$23,000 in interest up to December 31, 1986. Neither the bequest nor the interest income are reflected in these financial statements.

7. COMMITMENT

In the 1985 fiscal year a bequest was received from the Gollop Estate in the amount of \$66,000. Of this amount, \$9,000 was immediately transferred to the Canadian Dental Research Foundation. The balance of \$57,000 has been left in the general funds, however, it is managements intention to transfer this amount to the Canadian Dental foundation, referred to in note 6.

8. COMPARATIVE FIGURES

Comparative figures have been reclassified to conform with current presentation.

SCHEDULE OF REVENUE (page 9)

This and the subsequent schedule provide detail not shown in the statement of revenue and expenses on page 4. The totals, however, are the same.

Membership Fees

Membership fees are very close to budget and reflects the increase in membership fees in 1986 over 1985.

Accreditation

Again, accreditation revenue from surveys and grants is very close to budget and to the previous years activities.

Education

The Dental Aptitude Testing program revenue is up somewhat from budget and from the previous year. This is as a result of increased activity in this area. The grants are on target, but, it should be noted that the grant from CFDE, shown as \$15,000 in 1986, represents, in fact, the combination of the 1985 and 1986 grants. This is a timing problem again.

Communications

The Dental Awareness Program revenue showing as \$276,720 is a gross amount of revenue and incorporates monies received from corporations sponsoring programs in the Dental Awareness Program. The budget for this item was drawn up on a net basis; that is, revenue minus expenses. It is shown as a gross figure to more clearly delineate the volume of activity in this area.

Product Recognition revenue fell short of budget. This is, however, expected to be remedied in the coming year.

Publications show a fairly significant increase in revenue due to the increased activities in this area.

Finally, the convention surplus at \$22,496 is well above budget. This is largely the result of efforts by the committee to pare expenses.

Journal

Advertising revenue was well short of budget and actually fell short of the total from the previous year. This is due almost entirely to the circulation problem which the board has addressed.

Other Revenue

Interest income was well above budget but still below the previous year's total. This is a factor of cash flow and interest rates. The rental income is well below the budget and previous years total, due to the fact that rental space was unoccupied for several months during 1986.

The FDI revenue represents the balance of funds received from Canadian members of FDI, after the appropriate portion is forwarded to FDI in London. The difference represents the administration fee charged by the association to handle this program.

The miscellaneous income is well below the previous year owing to the fact that, in 1985, the Association recognized the bequest from Dr. Gollop, an amount in excess of \$60,000.

SCHEDULE OF REVENUE

FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>		<u>1985</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
MEMBERSHIP FEES			
Active	\$1,952,964	\$1,971,552	\$1,870,867
Corporate	82,520	79,826	82,823
Affiliate	-	1,880	4,050
Supporting	10,080	4,576	7,209
Student	25,805	26,585	29,502
	<u>\$2,071,369</u>	<u>\$2,084,419</u>	<u>\$1,994,451</u>
ACCREDITATION			
Survey revenue	\$ 33,200	\$ 35,200	\$ 26,250
Grants - N.D.E.B.	15,000	15,000	15,000
Grants - Transfer of corporate fee	62,175	62,769	61,723
	<u>\$ 110,375</u>	<u>\$ 112,969</u>	<u>\$ 102,973</u>
EDUCATION			
D.A.T. revenue	\$ 140,000	\$ 176,047	\$ 151,146
Grants - Student Affairs	7,500	8,625	6,375
Grants - C.F.D.E.	7,500	15,000	1,140
	<u>\$ 155,000</u>	<u>\$ 199,672</u>	<u>\$ 158,661</u>
COMMUNICATIONS			
D.A.P. revenue (note 5)	\$ 20,000	\$ 276,720	\$ 22,700
Production recognition	24,000	10,000	15,000
Publications	75,000	87,413	78,728
Convention - net revenue (expense)	3,120	20,987	(52,758)
	<u>\$ 122,120</u>	<u>\$ 395,120</u>	<u>\$ 63,670</u>
JOURNAL			
Advertising	\$ 430,000	\$ 375,633	\$ 387,509
Subscriptions	16,000	15,977	14,639
Other	5,000	989	344
	<u>\$ 451,000</u>	<u>\$ 392,599</u>	<u>\$ 402,492</u>
OTHER REVENUE			
Interest	\$ 90,000	\$ 127,013	\$ 139,963
Rental	178,282	137,260	173,539
F.D.I. receipts	6,000	5,258	16,740
Miscellaneous	-	3,797	84,362
	<u>\$ 274,282</u>	<u>\$ 273,328</u>	<u>\$ 414,604</u>

SCHEDULE OF EXPENSES (pages 10 & 11)

Executive

In the executive department, and the other departments as well, the staff line is distorted due to the changes in accounting methodology employed at CDA. The cost of payroll and staff benefits has been apportioned to each department whereas in previous years it was totaled under the administration department. Staff expenses were, in fact, significantly below the previous year and well below budget. This is largely the result of staff turn over and the resulting vacancies during this period.

Management committee expenses were above budget and previous year actuals. This is due primarily to two factors. One, the increase in per diems approved by the board the previous year and a change in the accounting methodology employed by CDA where an increased effort has been made to assign the costs incurred by the various project areas to that project area.

This has also impacted the Executive Council expenses which are lower than budget and significantly lower than the previous year.

The decrease in executive liaison expenses is due primarily to a reduction in the activity in this area.

The President's expense is higher than budget. Part of the explanation for this is the increases in the per diems, but also the geographic location of the President.

The expenses of the various councils and committees in the Executive department depict the activities in these areas.

The Board of Governors expenses are significantly higher than budget and the previous year because the meeting was held in Halifax, as opposed to Ottawa.

The professional services expenses are reasonably close to budget for 1986 but well below 1985. The 1985 expenses include the executive search fees, as well as, other legal and consulting fees.

And finally the other expense at \$91,000 is well above budget but below the previous year actual. The other expense includes such things as, unspecified expenses, the presidential installment, miscellaneous per diems, PRUC, prior expense, prelicensure conference and other Ad Hoc Committee expense.

Administration

Expenses in the area of Administration were very close to budget in all areas, albeit somewhat higher in the operations area.

Again one should note the change in accounting methodology which impacts the staff expense.

CANADIAN DENTAL ASSOCIATION

SCHEDULE OF EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1986

	1986		1985
	Budget	Actual	Actual
EXECUTIVE			
Staff	\$ 160,700	\$ 191,615	\$ 64,900
Management Committee	134,232	142,587	134,797
Executive Council	68,908	63,024	85,498
Executive Council Liaison	25,124	9,247	35,236
President	65,200	96,529	82,174
Taxation	7,878	5,562	3,638
Constitution and By-laws	8,060	1,281	-
Ethics	4,680	841	3,138
Nominations	2,626	-	-
Salaried dentists	4,368	102	1,914
Government relations	26,408	5,146	325
Board of Governors	99,824	115,327	86,170
Specialty Sections	6,500	5,994	3,885
Presidents and C.E.O.'s	11,102	11,863	9,042
F.D.I. Congress	20,500	19,467	16,084
Professional services	20,000	29,039	63,686
Grants	11,000	14,600	11,500
Other	65,190	90,976	99,790
	<u>\$ 742,300</u>	<u>\$ 803,200</u>	<u>\$ 701,777</u>
ADMINISTRATION			
Staff	\$ 324,879	\$ 277,751	\$ 575,409
Operations	230,910	245,045	228,919
Membership	57,828	47,234	44,172
F.D.I.	20,000	-	29,679
Equipment	41,000	35,300	42,633
Data processing	39,000	40,402	40,912
Property	283,550	283,505	253,426
	<u>\$ 997,167</u>	<u>\$ 929,237</u>	<u>\$1,215,150</u>

Accreditation

The increase in third party plans is related directly to increased activity.

The decrease in school surveys, represents the fact that fewer surveys were conducted in 1986 than planned.

The Hospital Services Council took steps to reduce costs in their area as did the Council on Dental Materials and Devices. It should be noted that some \$20,000 was budgeted for the development of standards in conjunction with the Canadian Standards Association. This project, however, was postponed.

Education

Most expenses under the area of education were in line with budget and previous year activity.

The Dental Aptitude Test program expenses were higher as a result of the increased activity.

The Information Services line item includes the Dental Awareness Program which is the lion's share of the amount. Again, it should be pointed out that the item has been recorded in the statements on a gross basis, rather than net of any revenues. This is again to show the amount of activity in the area. The Dental Awareness Program expense was within \$20,000 of budget.

Journal

All expenses in the area of the Journal were relatively close to budget.

CANADIAN DENTAL ASSOCIATION

SCHEDULE OF EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>		<u>1985</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
ACCREDITATION			
Staff	\$ 100,512	\$ 114,683	\$ 36,288
Third party plans	22,118	41,413	21,121
Education and accreditation	46,156	46,122	57,878
School surveys	81,900	61,302	48,449
Health care	19,826	15,255	25,204
Hospital services	33,870	18,473	19,304
Hospital surveys	8,280	5,524	9,587
Dental materials and devices	38,554	6,328	11,769
	<u>\$ 351,216</u>	<u>\$ 309,100</u>	<u>\$ 229,600</u>
EDUCATION			
Staff	\$ 190,460	\$ 185,616	\$ 55,395
Product recognition	14,586	7,886	7,251
Library	15,515	19,125	19,355
Student affairs	50,418	49,256	46,900
D.A.T.	133,168	143,656	113,112
Information services (note 5)	423,600	674,035	489,965
Conferences	22,500	29,379	11,155
	<u>\$ 850,247</u>	<u>\$1,108,953</u>	<u>\$ 743,133</u>
JOURNAL			
Staff	\$ 128,448	\$ 107,501	\$ 106,793
Editorial Board	7,124	6,233	8,422
Production	391,320	396,865	358,826
Sales	102,300	101,019	84,744
	<u>\$ 629,192</u>	<u>\$ 611,618</u>	<u>\$ 558,785</u>

THE CANADIAN DENTAL RESEARCH FOUNDATION (page 12)

The audited financial statements of the Canadian Dental Research Foundation is included together with the CDA statement as opposed to the previous year's practice were it was published separately.

Mc CAY. DUFF & COMPANY

CHARTERED ACCOUNTANTS

Page 12.

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.ADMIN., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.
G. WARREN TRICKEY, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

AUDITORS' REPORT

To the Members,
The Canadian Dental Research
Foundation.

We have examined the balance sheet of The Canadian Dental Research Foundation as at December 31, 1986 and the statement of revenue and expense for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Foundation as at December 31, 1986 and the results of its operations for the year then ended in accordance with the accounting policy as described in note 1, applied on a basis consistent with that of the preceding year.

McCay Duff & Co

Chartered Accountants.

Ottawa, Ontario,
January 19, 1987.

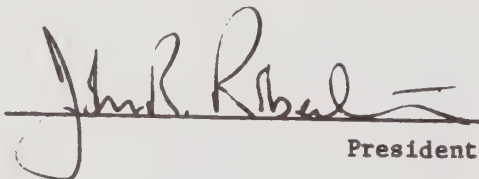
THE CANADIAN DENTAL RESEARCH FOUNDATION

BALANCE SHEET

AS AT DECEMBER 31, 1986

	ASSETS	<u>1986</u>	<u>1985</u>
CURRENT			
Cash		\$32,192	\$16,020
Deposit certificate		-	12,000
Accrued interest receivable		<u>119</u>	<u>85</u>
		32,311	28,105
INVESTMENTS (note 2)		<u>12,000</u>	<u>12,000</u>
		<u>\$44,311</u>	<u>\$40,105</u>
MEMBERS' EQUITY			
SURPLUS - BEGINNING OF YEAR		\$40,105	\$28,360
Excess of revenue over expense for the year		4,206	2,745
Transfer of bequest from Canadian Dental Association		<u>-</u>	<u>9,000</u>
SURPLUS - END OF YEAR		<u>\$44,311</u>	<u>\$40,105</u>

Approved on behalf of the Board:


 President


 Executive Director

THE CANADIAN DENTAL RESEARCH FOUNDATION
STATEMENT OF REVENUE AND EXPENSE
FOR THE YEAR ENDED DECEMBER 31, 1986

	<u>1986</u>	<u>1985</u>
REVENUE		
Interest	\$ 4,206	\$ 3,945
EXPENSE		
Award	<u>-</u>	<u>1,200</u>
EXCESS OF REVENUE OVER EXPENSE FOR THE YEAR	<u>\$ 4,206</u>	<u>\$ 2,745</u>

THE CANADIAN DENTAL RESEARCH FOUNDATION

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 1986

1. ACCOUNTING POLICY

Revenue and expenses are recognized on the accrual basis.

2. INVESTMENTS

Investments are stated at cost, which approximates market value.

	<u>Cost</u>
\$7,000 Canada Trust Corporation 11.75% debenture, due April 18, 1987	\$ 7,000
\$5,000 Hydro-Electric Power Commission of Ontario 9% bond, due April 1, 1994	<u>5,000</u>
	<u>\$12,000</u>

3. COMPARATIVE FIGURES

Certain comparative figures have been reclassified to conform with current presentation.

ASSOCIATION DENTAIRE CANADIENNE

ETATS FINANCIERS

LE 31 DECEMBRE 1986

ASSOCIATION DENTAIRE CANADIENNE

INDEX AUX ETATS FINANCIERS

LE 31 DECEMBRE 1986

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1	Rapport des vérificateurs
2	Bilan
3	Etat de l'avoir
4	Etat des résultats
5	Fonds en fiducie pour la bibliothèque Etat de l'avoir et des résultats
6	Fonds "Grieve Memorial Lectureship" Etat des résultats et de l'avoir
7 & 8	Notes complémentaires
9	Tableau des revenus Cotisations Accréditation Education Communication Journal Autres revenus
10	Tableau des dépenses Exécutif Administration
11	Tableau des dépenses Accréditation Services d'éducation Journal
	La Fondation Canadienne de Recherches Dentaires
12	Rapport des vérificateurs
13	Bilan
14	Etat des résultats
15	Notes complémentaires

MC CAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS

Page 1.

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RAPPORT DES VERIFICATEURS

Aux membres de
l'Association Dentaire
Canadienne

Nous avons vérifié le bilan de l'Association Dentaire Canadienne au 31 décembre 1986 ainsi que les états de l'avoir et des résultats, de l'avoir et des résultats du fonds en fiducie pour la bibliothèque et du fonds "Grieve Memorial Lectureship" et de l'évolution de la situation financière de l'exercice terminé à cette date. Notre vérification a été effectuée conformément aux normes de vérification généralement reconnues, et a comporté par conséquent les sondages et autres procédés que nous avons jugés nécessaires dans les circonstances.

A notre avis, ces états financiers présentent fidèlement la situation financière de l'Association au 31 décembre 1986 ainsi que les résultats de son exploitation et l'évolution de sa situation financière pour l'exercice terminé à cette date selon les principales conventions comptables décrit à la note 1, appliqués de la même manière qu'au cours de l'exercice précédent.

Mc Cay Duff & Co

Comptables agréés

Ottawa, Ontario,
le 22 janvier 1987

BILAN

AU 31 DECEMBRE 1986

	ACTIF	1986	1985
ACTIF A COURT TERME			
Encaisse		\$ 417,179	\$ 778,036
Encaisse - Fonds pour éventualités (bâtiment)		2,674	25,445
Certificat de dépôt		495,390	750,000
Comptes à recevoir		53,095	150,769
Stocks (note 1)		41,210	49,457
Frais payés d'avance		23,152	64,006
		<u>1,032,700</u>	<u>1,817,713</u>
ACTIF IMMOBILISE (notes 1 et 2)		<u>1,369,829</u>	<u>1,379,134</u>
		<u>2,402,529</u>	<u>3,196,847</u>

ACTIF DU FONDS EN FIDUCIE

Encaisse	46,910	52,703
Obligations et certificat de dépôt	302	1,276
Frais payés d'avance	7,876	5,300
Livres de bibliothèque et mobilier (à la valeur nominale)	1	1
	<u>55,089</u>	<u>59,280</u>
	<u>\$2,457,618</u>	<u>\$3,256,127</u>

PASSIF

PASSIF A COURT TERME		
Comptes à payer	\$ 95,656	\$ 147,095
Revenu reporté	284,912	696,640
Partie courante de la dette à long terme	27,150	27,150
	<u>407,718</u>	<u>870,885</u>
DETTE A LONG TERME (note 3)	<u>468,337</u>	<u>495,487</u>
	<u>876,055</u>	<u>1,366,372</u>

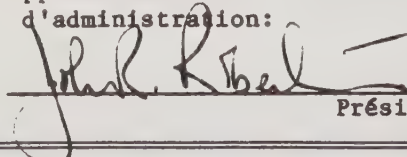
AVOIR

SURPLUS	652,132	973,978
AVOIR EN ACTIF IMMOBILISE (note 4)	874,342	856,497
	<u>1,526,474</u>	<u>1,830,475</u>
	<u>2,402,529</u>	<u>3,196,847</u>

AVOIR DU FONDS EN FIDUCIE

Fonds en fiducie pour la bibliothèque	48,242	51,533
Fonds en fiducie "Grieve Memorial Lectureship"	6,847	7,747
	<u>55,089</u>	<u>59,280</u>
	<u>\$2,457,618</u>	<u>\$3,256,127</u>

Approuvé au nom du conseil
d'administration:


Président

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Directeur exécutif

ASSOCIATION DENTAIRE CANADIENNE

ETAT DE L'AVOIR

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	<u>1986</u>	<u>1985</u>
SURPLUS		
SOLDE AU DEBUT DE L'EXERCICE	\$973,978	\$1,141,479
Excédent des revenus sur les dépenses (dépenses sur les revenus) pour l'exercice	(304,001)	(311,594)
Virement de (à) l'avoir en actif immobilisé	(17,845)	153,093
Virement de legs à la Fondation Canadienne de Recherches Dentaires	<u>-</u>	(<u>9,000</u>)
SOLDE A LA FIN DE L'EXERCICE	<u>\$652,132</u>	<u>\$ 973,978</u>
 AVOIR EN ACTIF IMMOBILISE		
SOLDE AU DEBUT DE L'EXERCICE	\$856,497	\$1,009,590
Virement du (au) surplus	<u>17,845</u>	(<u>153,093</u>)
SOLDE A LA FIN DE L'EXERCICE	<u>\$874,342</u>	<u>\$ 856,497</u>

ASSOCIATION DENTAIRE CANADIENNE

ETAT DES RESULTATS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	<u>1986</u>		<u>1985</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
REVENUS			
Cotisations (page 9)	\$2,071,369	\$2,084,419	\$1,994,451
Accréditation (page 9)	110,375	112,969	102,973
Education (page 9)	155,000	199,672	158,661
Communications (page 9)	122,120	395,120	63,670
Journal (page 9)	451,000	392,599	402,492
Autres (page 9)	<u>274,282</u>	<u>273,328</u>	<u>414,604</u>
	3,184,146	3,458,107	3,136,851
DEPENSES			
Exécutif (page 10)	742,300	803,200	701,777
Administration (page 10)	997,167	929,237	1,215,150
Accréditation (page 11)	351,216	309,100	229,600
Services d'éducation (page 11)	850,247	1,108,953	743,133
Journal (page 11)	<u>629,192</u>	<u>611,618</u>	<u>558,785</u>
	<u>3,570,122</u>	<u>3,762,108</u>	<u>3,448,445</u>
EXCEDENT DES REVENUS SUR LES DEPENSES (DEPENSES SUR LES REVENUS) POUR L'EXERCICE			
	(\$ <u>385,976</u>)	(\$ <u>304,001</u>)	(\$ <u>311,594</u>)

ASSOCIATION DENTAIRE CANADIENNE
FONDS EN FIDUCIE POUR LA BIBLIOTHEQUE
ETAT DE L'AVOIR ET DES RESULTATS
POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	<u>1986</u>	<u>1985</u>
REVENUS		
Intérêts	\$ 3,484	\$ 3,662
Dons	<u>4,444</u>	<u>2,011</u>
	7,928	5,673
DEPENSES		
Livres	2,514	1,378
Divers	330	214
Abonnements	<u>8,375</u>	<u>7,512</u>
	<u>11,219</u>	<u>9,104</u>
EXCEDENT DES REVENUS SUR LES DEPENSES (DEPENSES SUR LES REVENUS) POUR L'EXERCICE	(3,291)	(3,431)
Avoir au début de l'exercice	<u>51,533</u>	<u>54,964</u>
AVOIR A LA FIN DE L'EXERCICE	<u>\$48,242</u>	<u>\$51,533</u>

ASSOCIATION DENTAIRE CANADIENNE
FONDS "GRIEVE MEMORIAL LECTURESHIP"
ETAT DES RESULTATS ET DE L'AVOIR
POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	<u>1986</u>	<u>1985</u>
REVENU		
Intérêts	\$ 560	\$ 545
DEPENSE		
Prix	<u>1,460</u>	<u>-</u>
EXCEDENT DU REVENU SUR LA DEPENSE (DEPENSE SUR LE REVENU) POUR L'EXERCICE	(900)	545
Avoir au début de l'exercice	<u>7,747</u>	<u>7,202</u>
AVOIR A LA FIN DE L'EXERCICE	<u>\$6,847</u>	<u>\$7,747</u>

NOTES COMPLEMENTAIRES

31 DECEMBRE 1986

1. PRINCIPALES CONVENTIONS COMPTABLES

(a) Revenus et dépenses

Les revenus de dépenses sont comptabilisés sur une base d'exercice.

(b) Stocks

Les stocks sont évalués au moindre du coût et de la valeur de réalisation nette.

(c) Amortissement

L'achat de mobilier et d'équipement après le premier janvier 1979 est imputé aux résultats de l'exercice. Les acquisitions après cette date ont été complètement amortis.

L'actif immobilisé est amorti selon la méthode linéaire comme suit:

Immeubles	- 40 ans
Améliorations locatives	- 5 ans
Equipement pour traitement de l'information	- 5 ans

2. ACTIF IMMOBILISE

	1986			1985
	Coût	Amortissement accumulé	Net	Net
Terrain	\$ 82,915	\$ -	\$ 82,915	\$ 82,915
Immeubles	1,543,034	384,189	1,158,845	1,198,092
Améliorations locatives	159,105	88,499	70,606	32,747
Mobilier et équipement	75,769	75,768	1	1
Equipement pour traitement de l'information	125,927	81,003	44,922	52,839
Chaise de bureau	12,540	-	12,540	12,540
	<u>\$1,999,290</u>	<u>\$629,459</u>	<u>\$1,369,829</u>	<u>\$1,379,134</u>

3. DETTE A LONG TERME

	1986	1985
Hypothèque	\$495,487	\$ 522,637
Partie courante	27,150	27,150
	<u>\$ 468,337</u>	<u>\$ 495,487</u>

L'hypothèque sur l'immeuble avec la Banque Toronto-Dominion porte un taux d'intérêt équivalent au taux préférentiel de la banque, des mensualités de \$2,262 en capital plus les intérêts et arrive à échéance en 2005.

NOTES COMPLEMENTAIRES

31 DECEMBRE 1986

4. AVOIR EN ACTIF IMMOBILISE

	<u>1986</u>	<u>1985</u>
Solde au début de l'exercice	\$856,497	\$1,009,590
Acquisition d'actif immobilisé	64,115	43,217
Diminution (augmentation) de l'hypothèque	27,150 (	118,250)
Amortissement	(73,420)(	78,060)
	<u>17,845 (</u>	<u>153,093)</u>
Solde à la fin de l'exercice	<u>\$874,342</u>	<u>\$ 856,497</u>

5. PROGRAMME DENTAIRE DE SENSIBILISATION

Le budget pour le revenu du programme dentaire de sensibilisation était prévu net des dépenses applicables; cependant, l'effectif rapporte tous les revenus obtenus incluant les recettes provenant de matériel de promotion et de subventions professionnelles. La partie des dépenses pour les services d'information sous éducation inclut les dépenses du Conseil et les coûts complets du programme dentaire de sensibilisation. Ces coûts incluent les dépenses pour le développement du programme en plus des services de consultation fournis par "Manifest Communications."

6. FONDS EN FIDUCIE

L'Association détient des fonds en fiducie pour la Fondation dentaire canadienne qui sera incorporé en 1987. En Octobre 1986 une legs de \$1,360,000 at été reçu à l'intention du "Sydney Wood Bradley Memorial Library." Les fonds ont accumulés approximativement \$23,000 de revenu d'intérêt au 31 décembre 1986. Le legs ni le revenue d'intérêt ont été reflétés dans ces états financiers.

7. ENGAGEMENT

Un legs a été reçu de la succession de Gollop un montant de \$66,000 durant l'année financière 1985. De ce montant, un legs de \$9,000 a été immédiatement transféré à la Fonction canadienne de recherches dentaires. Le solde de \$57,000 a été laissé dans les fonds généraux, mais l'intention de la gestion est de transférer ce montant à la Fondation dentaire canadienne dont il est question à la note 6.

8. CHIFFRES COMPARATIFS

Certains chiffres de l'exercice précédent one été regroupés pour fins de présentation comparative.

TABLEAU DES REVENUS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	1986		1985
	Budget	Actual	Actual
COTISATIONS			
Membres actifs	\$1,952,964	\$1,971,552	\$1,870,867
Membres corporatifs	82,520	79,826	82,823
Membres affiliés	-	1,880	4,050
Membres de soutien	10,080	4,576	7,209
Etudiants	25,805	26,585	29,502
	<u>\$2,071,369</u>	<u>\$2,084,419</u>	<u>\$1,994,451</u>
ACCREDITATION			
Programme d'agrément	\$ 33,200	\$ 35,200	\$ 26,250
Subvention - B.N.E.D.	15,000	15,000	15,000
Subvention - virement des membres corporatifs	62,175	62,769	61,723
	<u>\$ 110,375</u>	<u>\$ 112,969</u>	<u>\$ 102,973</u>
EDUCATION			
Revenu programme de test d'aptitudes dentaires	\$ 140,000	\$ 176,047	\$ 151,146
Subvention - affaires étudiantes	7,500	8,625	6,375
Subvention - F.C.E.D.	7,500	15,000	1,140
	<u>\$ 155,000</u>	<u>\$ 199,672</u>	<u>\$ 158,661</u>
COMMUNICATIONS			
Le mois de la santé dentaire (note 5)	\$ 20,000	\$ 276,720	\$ 22,700
Acceptation de produits	24,000	10,000	15,000
Publications	75,000	87,413	78,728
Convention - revenus net (dépendances)	3,120	20,987	(52,758)
	<u>\$ 122,120</u>	<u>\$ 395,120</u>	<u>\$ 63,670</u>
JOURNAL			
Publicité	\$ 430,000	\$ 375,633	\$ 387,509
Abonnements	16,000	15,977	14,639
Autres	5,000	989	344
	<u>\$ 451,000</u>	<u>\$ 392,599</u>	<u>\$ 402,492</u>
AUTRES REVENUS			
Intérêts	\$ 90,000	\$ 127,013	\$ 139,963
Loyer	178,282	137,260	173,539
F.D.I.	6,000	5,258	16,740
Divers	-	3,797	84,362
	<u>\$ 274,282</u>	<u>\$ 273,328</u>	<u>\$ 414,604</u>

ASSOCIATION DENTAIRE CANADIENNE

TABLEAU DES DEPENSES

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	1986		1985
	Budget	Actual	Actual
EXECUTIF			
Personel	\$ 160,700	\$ 191,615	\$ 64,900
Comité de gestion	134,232	142,587	134,797
Conseil exécutif	68,908	63,024	85,498
Conseil exécutif - liaison	25,124	9,247	35,236
Président	65,200	96,529	82,174
Impôts	7,878	5,562	3,638
Statuts et des règlements	8,060	1,281	-
Ethique	4,680	841	3,138
Nominations	2,626	-	-
Dentistes salariés	4,368	102	1,914
Relations gouvernementales	26,408	5,146	325
Conseil des gouverneurs	99,824	115,327	86,170
Section des spécialités	6,500	5,994	3,885
Présidents et officiers en chef	11,102	11,863	9,042
Congres - F.D.I.	20,500	19,467	16,084
Services professionnelles	20,000	29,039	63,686
Subventions	11,000	14,600	11,500
Autres	65,190	90,976	99,790
	<u>\$ 742,300</u>	<u>\$ 803,200</u>	<u>\$ 701,777</u>
ADMINISTRATION			
Personel	\$ 324,879	\$ 277,751	\$ 575,409
Opérations	230,910	245,045	228,919
Cotisations	57,828	47,234	44,172
F.D.I.	20,000	-	29,679
Equipement de bureau	41,000	35,300	42,633
Ordinateures	39,000	40,402	40,912
Gestions d'immeubles	283,550	283,505	253,426
	<u>\$ 997,167</u>	<u>\$ 929,237</u>	<u>\$1,215,150</u>

ASSOCIATION DENTAIRE CANADIENNE

TABLEAU DES DEPENSES

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	1986		1985
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
ACCREDITATION			
Personel	\$ 100,512	\$ 114,683	\$ 36,288
Régime de paiement d'un trois parti	22,118	41,413	21,121
Education et accréditation	46,156	46,122	57,878
Etude - écoles	81,900	61,302	48,449
Soins de santé	19,826	15,255	25,204
Services hospitaliers	33,870	18,473	19,304
Etude - hôpital	8,280	5,524	9,587
Matériaux et appareils dentaires	<u>38,554</u>	<u>6,328</u>	<u>11,769</u>
	<u>\$ 351,216</u>	<u>\$ 309,100</u>	<u>\$ 229,600</u>
EDUCATION			
Personel	\$ 190,460	\$ 185,616	\$ 55,395
Acceptation de produits	14,586	7,886	7,251
Bibliothèque	15,515	19,125	19,355
Affaires étudiantes	50,418	49,256	46,900
T.A.D.	133,168	143,656	113,112
Services d'information (note 5)	423,600	674,035	489,965
Conférences	<u>22,500</u>	<u>29,379</u>	<u>11,155</u>
	<u>\$ 850,247</u>	<u>\$ 1,108,953</u>	<u>\$ 743,133</u>
JOURNAL			
Personel	\$ 128,448	\$ 107,501	\$ 106,793
Comité de éducation	7,124	6,233	8,422
Production	391,320	396,865	358,826
Ventes	<u>102,300</u>	<u>101,019</u>	<u>84,744</u>
	<u>\$ 629,192</u>	<u>\$ 611,618</u>	<u>\$ 558,785</u>

Mc CAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS

Page 12

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.ADMIN., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.
G. WARREN TRICKEY, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

RAPPORT DES VERIFICATEURS

Aux membres de
La Fondation Canadienne de
Recherches Dentaires,

Nous avons vérifié le bilan de la Fondation Canadienne de Recherches Dentaires au 31 décembre 1986 ainsi que l'état des résultats pour l'exercice terminé à cette date. Notre vérification a été effectuée conformément aux normes de vérification généralement reconnues, et a comporté par conséquent les sondages et autres procédés que nous avons jugés nécessaires dans les circonstances.

A notre avis, ces états financiers présentent fidèlement la situation financière de la Fondation au 31 décembre 1986 ainsi que les résultats de son exploitation pour l'exercice terminé à cette date selon conventions comptables décrit à la note 1, appliqués de la même manière qu'au cours de l'exercice précédent.

McCay Duff & Co

Comptables agréés

Ottawa, Ontario,
le 19 janvier 1987

LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

BILAN

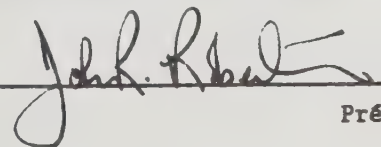
AU 31 DECEMBRE 1986

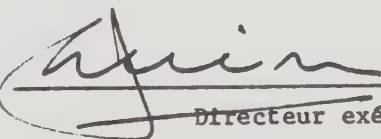
ACTIF	<u>1986</u>	<u>1985</u>
ACTIF A COURT TERME		
Encaisse	\$32,192	\$16,020
Certificats de dépôts	-	12,000
Intérêts courus à recevoir	<u>119</u>	<u>85</u>
	32,311	28,105
PLACEMENTS (note 2)	<u>12,000</u>	<u>12,000</u>
	<u>\$44,311</u>	<u>\$40,105</u>

AVOIR DES MEMBRES

SOLDE AU DEBUT DE L'EXERCICE	\$40,105	\$28,360
Excédent du revenu sur la dépense pour l'exercice	4,206	2,745
Virement de legs de l'association dentaire canadienne	<u>-</u>	<u>9,000</u>
SURPLUS A LA FIN DE L'EXERCICE	<u>\$44,311</u>	<u>\$40,105</u>

Approuvé au nom du conseil d'administration:


Président


Directeur exécutif

LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

ETAT DES RESULTATS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1986

	<u>1986</u>	<u>1985</u>
REVENU		
Intérêts	\$ 4,206	\$ 3,945
DEPENSE		
Prix	<u>-</u>	<u>1,200</u>
EXCEDENT DU REVENU SUR LA DEPENSE POUR L'EXERCICE	<u>\$ 4,206</u>	<u>\$ 2,745</u>

LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

NOTES COMPLEMENTAIRES

31 DECEMBRE 1986

1. PRINCIPALES CONVENTIONS COMPTABLES

Les revenus et dépenses sont comptabilisés sur une base d'exercice.

2. PLACEMENTS

Les placements comptabilisés au coût d'acquisition qui représente approximativement la valeur du marché.

	<u>Coût</u>
Débeture de \$7,000 de la compagnie Canada Trust à 11.75%, échéant le 18 avril 1987	\$ 7,000
Obligations de \$5,000 de la Commission d'Energie Hydro Electrique de l'Ontario à 9%, échéant le 1er avril 1994	<u>5,000</u>
	<u>\$12,000</u>

3. CHIFFRES COMPARATIFS

Certains chiffres de l'exercice précédent ont été regroupés pour fins de presentation comparative.

CANADIAN DENTAL ASSOCIATION

1987 Budget

(Revised)

Prepared : 6 March, 1987

Explanatory Notes

A Revised Budget

Based on an Executive directive to accomodate program priorities, CDA staff worked to revise the income and expense projections for 1987. In consultation with Council and Committee Chairmen, staff pared expenses wherever possible. Utilizing more current information on 1986 financial results, the staff also adjusted their original estimates. The objective of the exercise was to determine if sufficient monies could be freed up to fund new and necessary programs without sacrificing existing operations.

The attached budget reflects the action taken by the staff to meet this objective. The results are disappointing in that they not only do not free up the necessary finds but instead actually push the bottom line slightly under our goal of a balanced budget.

Much effort was put into trying to free up resources. Some Councils opted to cut back or even forego meetings in 1987. This action was unfortunately overshadowed by the impact of adjusting the budget to better reflect the ongoing programs and committments.

The resulting revised budget was then presented to the Management Committee and subsequently to the Executive Council. From discussions in this forum, further adjustments were proposed and are now incorporated into this version. The principle changes are summarized on the next page.

The Format

The numbers presented in this revised budget were compiled using the same principles as with the original 1987 budget presented to the Board of Governors in August. (For the readers interest, the notes accompanying that version of the budget are appended at the end of this document).

The format is similar to the original submission but has taken yet another step towards a simplified presentation. Our intention here is to present as much useful data as possible without burdening you with a barrage of numbers.

The changes made to the budget reflect efforts made to curtail activities and to better project future income and expenditures based on 1986 actual results. It must be clearly pointed out, however, that the 1986 results presented here are unaudited. At the time this document was prepared the final version of the audited statements were not available. It can be safely assumed, that the actual results are different than presented due to year end accruals and other customary adjustments.

The inclusion of these unaudited numbers is intended to simply provide a better baseline to measure against than the "four months to date" numbers used in the original budget.

A Good Exercise

The exercise of reviewing the original budget, struck early in the year using several assumptions, is valuable and should be a regular activity. The result is a better budget which should more accurately project the Association's income and expenses for the current year.

PRINCIPLE CHANGES TO THE ORIGINAL 1987 BUDGET

REVENUE

1. Membership revenue was adjusted to reflect current demographics
2. Projected sales of pamphlets were increased based on experience
3. Term deposit and current account interest projections were adjusted to reflect current trends
4. Rental income was adjusted slightly to reflect the current situation

EXPENDITURE

1. Per Diems were rolled back to reflect the Executive Council decision to waive the proposed cost of living adjustment (COLA)
2. Board of Governors expenses were increased to reflect more accurate estimates
3. Monies have been allocated to the Taxation Committee to fund a special project
4. Constitution & Bylaws expenses were reduced to reflect activity
5. President's & CEO's meeting expenses were reduced to reflect the new policy on expense claims
6. The Unaccountable Expense item has been eliminated
7. Funds have been allocated to the Manpower Symposium (known now as PRUC) and Roles & Responsibility to reflect activity
8. Funds included in the 1986 budget (but not spent) for the CIDA project in Haiti have been carried over into 1987
9. The Administration staff expense has been adjusted upward to reflect the current staffing costs

10. Several of the employer paid payroll expenses and benefit program cost have been adjusted based on actual costs
11. Postage has been increased slightly to reflect the increased postal rates
12. Membership Committee expenses have been adjusted to reflect the proposed new structure of the committee and to accomodate the activity plan. (\$10,000 of the \$15,000 budgeted for a workshop has been turned back to general operations - \$5,000 has been retained for a membership survey)
13. The office equipment-purchases budget has been increased to provide for the purchase of additional equipment including the computerized monitoring system for the Heating/Cooling System
14. Accreditation staff expenses is increased to reflect current staff costs
15. \$20,000 has been added to the Third Party Plans budget to cover increased activity
16. Hospital Services have cut a planned meeting in 1987
17. Dental Materials and Devices have cut a meeting planned for 1987
18. Educational Service staff has been reduced to reflect current staffing costs
19. Journal staff expense has been reduced slightly to reflect current staffing costs
20. Layout and postage expenses have been reduced based on new projections

CANADIAN DENTAL ASSOCIATION
BUDGET - INCOME STATEMENT
FOR THE YEAR ENDING DECEMBER 31, 1987

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
REVENUE			
MEMBERSHIP FEES	\$2,326,014	\$2,084,419	112%
ACCREDITATION	172,525	112,969	153
EDUCATION	165,000	199,672	83
COMMUNICATIONS	142,000	395,120	36
JOURNAL	508,300	392,600	129
OTHER	285,390	273,327	104
TOTAL REVENUE	\$3,599,229	\$3,458,107	104%
EXPENSE			
EXECUTIVE	\$780,745	\$822,971	95%
ADMINISTRATION	950,202	863,022	110
ACCREDITATION	398,361	322,464	124
EDUCATIONAL SERVICES	799,211	1,129,194	71
JOURNAL	675,847	624,456	108
TOTAL EXPENSE	\$3,604,366	\$3,762,107	96%
NET SURPLUS / (DEFICIT)	(\$5,137)	(\$304,000)	2%

02-Apr-87

(RBGT1987)

1987 BUDGET - REVENUE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
MEMBERSHIP FEES			
Active	\$2,180,146	\$1,971,552	111%
Corporate	99,768	79,826	125
Affiliate	5,200	1,880	277
Supporting	10,500	4,576	229
Student	30,400	26,585	114
Total	\$2,326,014	\$2,084,419	112
ACCREDITATION			
Survey Revenue	33,175	35,200	94
Grants - NDEB	15,000	15,000	100
Grants - Transfer of Corporate Fee	124,350	62,769	198
Total	\$172,525	\$112,969	153
EDUCATION			
DAT Revenue	150,000	176,047	85
Grants - Student Affairs	15,000	23,625	63
Grants - CIDA		0	ERR
Total	\$165,000	\$199,672	83
COMMUNICATIONS			
NDHM Revenue	33,000	276,720	12
Product Recognition	24,000	10,000	240
Publications	90,000	87,413	103
Convention	(5,000)	20,988	-24
Total	\$142,000	\$395,120	36
JOURNAL			
Advertising	490,800	375,633	131
Subscriptions	16,000	15,977	100
Other income	1,500	989	152
Total	\$508,300	\$392,600	129
OTHER			
Interest	105,000	127,013	83
Rental income	174,390	137,259	127
FDI Reciepts	6,000	5,258	114
Other income	0	3,797	0
Total	\$285,390	\$273,327	104
GRAND TOTAL	\$3,599,229	\$3,458,107	104%

02-Apr-87

(RBGT1987)

1987 BUDGET - REVENUE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
FEEES			
Active Fees - B.C.	\$449,672	\$406,575	111%
Active Fees - Alberta	307,244	278,150	110
Active Fees - Saskatchewan	85,900	77,668	111
Active Fees - Manitoba	118,400	107,053	111
Active Fees - Ontario	693,135	626,705	111
Active Fees - Quebec	340,996	308,315	111
Active Fees - N.B.	49,123	44,415	111
Active Fees - Nova Scotia	91,166	82,429	111
Active Fees - P.E.I.	10,916	9,870	111
Active Fees - Newfoundland	33,593	30,374	111
Corp. Fees - B.C.	17,690	14,152	125
Corp. Fees - Alberta	12,270	9,828	125
Corp. Fees - Saskatchewan	3,595	\$2,876	125
Corp. Fees - Manitoba	4,735	\$3,788	125
Corp. Fees - Ontario	41,110	\$32,888	125
Corp. Fees - Quebec	12,450	9,960	125
Corp. Fees - N.B.	2,400	1,920	125
Corp. Fees - Nova Scotia	3,560	2,848	125
Corp. Fees - P.E.I.	450	360	125
Corp. Fees - Newfoundland	1,508	1,206	125
Affiliate Fees - NWT	5,200	1,880	277
Associate	0	3,998	0
Supporting	10,500	578	1817
Student Fees	30,400	26,353	115
Student Membership post grad	0	0	ERR
Practice Management Manual	0	232	0
ACCREDITATION			
Survey Revenue Schools	17,500	13,200	133
Survey Revenue ACED	11,000	11,000	100
Survey Revenue 5/Year Schools	0	2,500	0
Survey Revenue Hospitals	4,675	8,500	55
Transfer Accreditation Grants	124,350	62,769	198
Grant - NDEB	15,000	15,000	100
DATP			
Applications Test	150,000	176,047	85
GRANTS			
Grants - Student Conference	7,500	8,625	87
Grants - Teaching Conference	7,500	15,000	50
Grants - St. Kitts		0	ERR
Grants - Haiti		0	ERR
PRODUCT RECOGNITION			
Product Recognition income	24,000	10,000	240
PAMPHLETS			
Pamphlet Sales	90,000	87,277	103
Sale Of Films	0	36	0
Sale of Library Packages	0	100	0
NAT. DENT. HEALTH MONTH			
NDHM income	33,000	80,560	41
DAP Special Projects		196,160	0
CDA CONVENTION			
Annual Convention - Net	(5,000)	20,988	-24

02-Apr-87

(RBGT1987)

1987 BUDGET - REVENUE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
JOURNAL REVENUE			
Sale Of Journal	16,000	15,977	100
Commercial Advertising Revenue	460,800	349,758	132
Classified Advertising Revenue	30,000	25,875	116
Sale Of Reprints	1,500	989	152
CDA Internal Advertising	0	0	ERR
INTEREST			
Term Deposit Interest	80,000	62,825	127
Current Account Interest	25,000	62,800	40
Other Interest	0	1,387	0
RENTAL REVENUE			
Rental Income Escalation	6,600	6,461	296
Rental Income - O.D.S.	1,500	975	5
Rental Income - C.C.H.A.	53,941	47,824	201
Rental Income - Clendenning	3,150	2,573	55
Rental Income - F.M.W.	2,310	2,226	13
Rental Income - SEVEC	60,120	30,060	-1860
Rental Income - Red Cross	23,867	26,777	ERR
Rental Income - Parking	6,120	5,711	ERR
Rental Income - R.C.F.C.	0	\$17,885	ERR
Rental Income - C.P.A.	0	-3232	ERR
Rental Income - M.St.B.	0		ERR
Rental Income - Ste. 105	9,117		ERR
Rental Income - Ste. 206	7,665		146
OTHER INCOME			
F.D.I. Pay./Rec.	6,000	5,258	114
Other Income	0	2,154	0
Foreign Exchange	0	1,643	0
TOTALS	\$3,599,229	\$3,458,107	104%

(1987EBCT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
EXECUTIVE			
Staff	\$220,111	\$211,387	104%
Board of Governors	111,210	115,327	96%
Executive Council	64,830	63,024	103%
Management Committee	135,030	142,587	95%
President	65,200	96,529	68%
Executive Council Liaison	20,600	9,247	223%
Taxation	11,955	5,562	215%
Government Relations	2,500	5,146	49%
Constitution & By-laws	475	1,281	37%
Ethics	5,964	841	709%
Nominations	1,812	0	ERR
Salaried Dentists	4,794	102	4702%
Specialty Sections	6,722	5,994	112%
Presidents & CEOs	6,940	11,853	58%
FDI Congress	20,000	19,457	103%
Legal	20,000	29,039	69%
Grants	13,000	14,600	89%
Awards	4,500	754	597%
Other	45,102	68,877	65%
Unbudgeted Projects	20,000	21,344	94%
Total	\$780,745	\$822,971	95%
ADMINISTRATION			
Staff	\$241,877	\$211,536	114%
Operations	243,865	245,045	100%
Membership	53,010	47,234	112%
FDI Admin	20,000	0	ERR
Equipment	61,000	35,300	173%
Data Processing	43,000	40,402	106%
Property	287,450	283,504	101%
Total	\$950,202	\$863,022	110%
ACCREDITATION			
Staff	\$151,226	\$128,048	118%
Third Party Plans	56,605	41,413	137%
Education & Accreditation	72,460	46,122	157%
School Surveys	62,220	61,302	101%
Health Care	18,280	15,255	120%
Hospital Services	15,215	18,473	82%
Hospital Surveys	12,455	5,524	225%
Dental Materials & Devices	9,900	6,328	156%
Total	\$398,361	\$322,464	124%
EDUCATIONAL SERVICES			
Staff	\$233,041	\$205,857	113%
Product Recognition	15,620	7,886	198%
Library	18,500	19,125	97%
Student Affairs	37,750	49,256	77%
DAT	115,750	143,656	81%
Information Services	360,550	674,035	53%
Conferences	18,000	29,379	61%
Total	\$799,211	\$1,129,194	71%
JOURNAL			
Staff	\$137,497	\$120,338	114%
Editorial Board	7,574	6,233	122%
Journal Production	439,646	396,865	111%
Journal Sales	91,130	101,019	90%
Total	\$675,847	\$624,456	108%
GRAND TOTAL	\$3,604,366	\$3,762,107	96%

(1987EBGT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
EXECUTIVE OFFICE			
Staff/Payroll	\$162,470	\$146,759	111%
Staff/Benefits-Transfer	26,441	19,772	134
Staff/Temporary	2,200	3,449	64
Staff/Misc. Expenses	0	753	0
Staff/T&A-Executive Director	28,000	36,005	78
Staff/T&A-Other	1,000	4,650	22
Board Of Governors/T&A	82,950	73,016	114
Board of Governors/PD	28,250	42,311	67
Executive Council/T&A	32,040	29,866	107
Executive Council/PD	32,790	33,158	99
Management Committee/T&A	25,000	23,311	107
Management Committee/PD	35,150	44,396	79
Management Committee/Honoraria	74,880	74,880	100
President's Expenses/T&A	31,400	46,678	67
President's Expenses/PD	33,800	49,851	68
Executive Council Liaison/T&A	8,000	2,110	379
Executive Council Liaison/PD	12,600	7,137	177
Taxation Committee/T&A	5,085	3,378	151
Taxation Committee/PD	1,870	2,184	86
Taxation Committee/Projects	5,000		
Government Relations/T&A	2,500	3,742	67
Government Relations/PD	0	1,404	0
Constitution & By-Laws/T&A	475	1,281	37
Constitution & By-Laws/PD	0	0	ERR
Ethics/T&A	5,340	529	1009
Ethics/PD	624	312	200
Nominations/T&A	1,500	0	ERR
Nominations/PD	312	0	ERR
Salaried Dentists/T&A	4,170	102	4090
Salaried Dentists/PD	624	0	ERR
Specialty Sections/T&A	6,255	5,994	104
Specialty Sections/PD	467	0	ERR
Presidents & CEOs/T&A	5,560	9,159	61
Presidents & CEOs/PD	1,380	2,704	51
FDI Congress/T&A	20,000	19,467	103
Legal & Consulting	20,000	29,039	69
Grants/Sponsorship	13,000	14,600	89
Awards/Nominations	4,500	754	597
Other/CPP-Per Diem	4,292	4,677	92
Other/Misc. Per Diem	3,120	7,598	41
Other/Unaccountable Expense	0	8,667	0
Other/Secretaries Conference	0	0	ERR
Other/President's Installation	15,000	11,120	135
Other/Manpower Symposium	6,208	25,252	25
Other/Roles & Responsibilities	8,482	502	1688
Other/Previous Year Expense	0	11,061	0
Other/St. Kitts		0	ERR
Other/Haiti	8,000	0	ERR
Unbudgeted Projects	20,000	21,344	94
Total	\$780,745	\$822,971	95%

(1987EBGT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
ADMINISTRATION			
Staff/Payroll	198,540	170,776	116%
Staff/Pension-Employer Paid	35,000	3,478	1006%
Staff/Special Benefits	7,200	6,168	117%
Staff/Canada Pension Plan	13,820	8,654	160%
Staff/Unemployment Insurance	9,100	15,539	59%
Staff/O.H.I.P.	9,740	8,598	113%
Staff/Blue Cross	6,300	4,949	127%
Staff/Group Plan CDSPI/53745	5,500	5,420	101%
Staff/Group Plan CDSPI/53744	31,500	26,888	117%
Staff/Group Plan CDSPI/Mgmt	4,750	4,088	116%
Staff/Training	2,000	767	261%
Staff/Personnel Advertising	1,000	4,247	24%
Staff/Misc. Benefits	0	428	0%
Staff/Transfer Accounts-Exec	(26,441)	(19,772)	134%
Staff/Transfer Accounts-Accred	(20,146)	(13,366)	151%
Staff/Transfer Accounts-Educ.	(28,959)	(20,241)	143%
Staff/Transfer Accounts-Journal	(17,627)	(12,837)	137%
Staff/Temporary	6,600	14,046	47%
Staff/Misc. Expenses	0	0	ERR
Staff/T&A-Dir. of Administration	2,000	\$1,969	102%
Staff/T&A-Other	2,000	1,738	115%
Operations/Office Supplies	21,000	26,473	79%
Operations/Postage	58,300	34,715	168%
Operations/Shipping And Delivery	7,500	12,031	62%
Operations/Memberships & Subs.	500	443	113%
Operations/Photography	0	(21)	0%
Operations/Admin. Charges	550	2,741	20%
Operations/Bad Debt Expense	0	(310)	0%
Operations/Misc. Office Expenses	5,000	5,002	100%
Operations/Meeting Supplies	4,000	15,712	25%
Operations/Tel. & Telegraph	65,000	65,824	99%
Operations/Translation	12,000	10,452	115%
Operations/Printing	31,000	39,976	78%
Operations/Duplicating	15,500	10,119	153%
Operations/Other Telephone Exp.	0	350	0%
Operations/Insurance-Exec Council	765	1,074	71%
Operations/Insurance-Gen & Liab	13,750	10,464	131%
Operations/Foreign Exchange	0	0	ERR
Operations/Audit And Financial	9,000	10,000	90%
Membership/T&A	6,950	3,711	187%
Membership/PD	4,060	884	459%
Membership/Promotion	10,000	8,926	112%
Membership/Campaign	32,000	33,713	95%
F.D.I. Administration Expense	20,000	0	ERR
Office Equipment/Purchases	30,000	7,428	404%
Office Equipment/Rental	26,000	21,961	118%
Office Equipment/Maintenance	5,000	5,912	85%
Data Processing/Expense	25,000	27,456	91%
Data Processing/Maintenance	11,000	9,039	122%
Data Processing/Software	2,000	99	2017%
Data Processing/Supplies	5,000	3,808	131%
Property/Dep'n Expense - Bldg	53,000	49,564	107%
Property/Mortgage Interest	50,000	53,845	93%
Property/Realty Tax	61,000	51,313	119%
Property/Light, Heat & Water	55,000	48,333	114%
Property/Insurance-Building	5,000	4,916	102%
Property/Plumbing & Electrical	1,500	1,249	120%
Property/Bldg. Main.-Supplies	5,000	8,946	56%
Property/Bldg. Main.-Cleaning	14,500	15,323	95%
Property/Bldg. Main.-Security	2,000	1,375	145%
Property/Fire Inspection	450	455	99%
Property/Grounds Main.-Supplies	500	\$0	ERR
Property/Grounds Main.-Labour	12,000	9,905	121%
Property/HVAC	15,000	15,423	97%
Property/Renovations	6,000	8,974	67%
Property/Legal	5,000	0	ERR
Property/Realty Fees	0	11,178	0%
Property/CFDE	0	0	ERR
Property/Miscellaneous	1,500	2,705	55%
Total	\$950,202	\$863,022	110%

(1987EBGT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
ACCREDITATION			
Staff/Payroll	121,380	99,206	122%
Staff/Benefits-Transfer	20,146	13,366	151
Staff/Temporary	2,200	360	611
Staff/Misc. Expenses	0	1,299	0
Staff/T&A-Dir. of Accred.	5,000	12,436	40
Staff/T&A-Other	2,500	1,381	181
Third Party Plans/T&A	22,555	36,967	61
Third Party Plans/PD	4,050	4,446	91
Third Party Plans/Projects	20,000	0	
Third Party Plans/Consultant	10,000	0	ERR
Educ. & Accred./T&A	19,200	22,410	86
Educ. & Accred./Chairman's T&A	6,120	3,568	172
Educ. & Accred./Documents T&A	8,010	6,805	118
Educ. & Accred./Cont. Educ. T&A	10,680	3,400	314
Educ. & Accred./Competency T&A	5,340	0	ERR
Educ. & Accred./Joint Advisory T&A			ERR
Educ. & Accred./PD	4,990	8,691	57
Educ. & Accred./Documents PD	1,870		ERR
Educ. & Accred./Cont. Educ. PD	0	1,248	0
Educ. & Accred./Joint Advisory P	0	0	ERR
Educ. & Accred./Competency PD	1,250	0	ERR
Educ. & Accred./Cont. Educ. Proj	15,000		ERR
Educ. & Accred./ACFD Task Force			ERR
School Surveys/University T&A	33,330	37,025	90
School Surveys/College T&A			ERR
School Surveys/Dir. of Accred. T	15,190	7,140	213
School Surveys/Univ. Survey PD	13,700	17,136	80
School Surveys/College Survey PD		0	ERR
Health Care/T&A	14,850	*13,539	110
Health Care/PD	3,430	1,716	200
Hosp. Services/T&A	4,500	11,802	38
Hosp. Services/Chairman's T&A	6,925	1,467	472
Hosp. Services/Joint Advis. T&A	0	794	0
Hosp. Services/PD	3,790	4,098	92
Hosp. Services/Joint Advis. PD	0	312	0
Hospital Surveys/T&A	8,640	3,874	223
Hospital Surveys/Dir. of Accred.	2,085	0	ERR
Hospital Surveys/Survey PD	1,730	1,650	105
Dental Mat. & Devices/T&A	8,340	5,548	150
Dental Mat. & Devices/PD	1,560	780	200
Dental Mat. & Devices/Std. Proj.			
Total	\$398,361	\$322,464	124%

(1987EBGT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
EDUCATIONAL SERVICES			
Staff/Payroll	177,982	150,239	118%
Staff/Benefits-Transfer	28,959	20,241	143%
Staff/Temporary	12,600	15,143	83%
Staff/Misc. Expenses	0	518	0%
Staff/T&A-Dir. Of Education	10,000	12,530	80%
Staff/T&A-Other	3,500	7,185	49%
Product Recognition/T&A	14,680	6,950	211%
Product Recognition/PD	940	936	100%
Library/Headline	8,500	10,860	78%
Library/Equip. Rental - DF & DS	700	646	108%
Library/Supplies & Services	2,000	1,769	113%
Library/Interlibrary Loans	7,000	5,485	128%
Library/Membr. & Seminar Fees	200	158	127%
Library/Ship -Translation	100	208	48%
Student Affairs/T&A	14,000	16,053	87%
Student Affairs/PD	1,250	1,677	75%
Student Affairs/Translation	1,000	148	674%
Student Affairs/Shipping & Posta	2,650	1,426	186%
Student Affairs/Promotion	7,000	8,356	84%
Student Affairs/Receptions	7,000	5,518	127%
Student Affairs/Awards	850	730	116%
Student Affairs/Pract Mgmt Manua	4,000	6,408	62%
Student Affairs	0	8,930	0%
Student Affairs/Misc	0	10	0%
DAT Committee/T&A	18,240	25,516	71%
DAT Committee/PD	1,250	3,901	32%
DAT/Test Supplies & New Mat.	20,000	5,553	360%
DAT/Translation	0	2,258	0%
DAT/Printing & Promotion	32,000	68,518	47%
DAT/Shipping & Postage	9,540	13,985	68%
DAT/Grading Test Papers	8,000	23	34379%
DAT/Validation	3,000	1,207	249%
DAT/Fee For Service	11,000	10,258	107%
DAT/Users Fee	1,600	690	232%
DAT/Chalk Graders	11,120	11,747	95%
Info. Services/T&A	12,510	13,830	90%
Info. Services/PD	2,340	5,772	41%
Info. Services/NDHM	75,000	85,404	88%
Info. Services/Dental Aware-Cons	150,000	437,067	34%
Info. Services/Dental Aware-Adm.	22,500	21,714	104%
Info. Services/Pamphlet Expense	65,000	64,468	101%
Info. Services/News. & Comun.	28,000	35,859	78%
Info. Services/Press Clippings	3,000	6,574	46%
Info. Services/Film Distribution	2,200	3,348	66%
Conference/Teaching	9,000	24,250	37%
Conference/Student	9,000	5,128	175%
Total	\$799,211	\$1,129,194	71%

(1987EBGT)

1987 BUDGET - EXPENSE

	1987 Budget	1986 Actual	1987 Budget/ 1986 Actual
JOURNAL			
Staff/Payroll	106,470	95,282	112%
Staff/Temporary	4,400	5,989	73%
Staff/Benefits-Transfer	17,627	12,837	137%
Staff/Misc. Expenses	0	998	0%
Staff/T&A-Journal Editor	6,000	3,577	168%
Staff/T&A-Other	3,000	1,655	181%
Editorial Board/T&A	6,950	5,297	131%
Editorial Board/PD	624	936	67%
Journal Prod./Translation	16,000	19,156	84%
Journal Prod./Layout	97,800	101,629	96%
Journal Prod./Postage	19,246	15,967	121%
Journal Prod./Shipping	15,000	16,840	89%
Journal Prod./Printing	271,000	228,616	119%
Journal Prod./Reprinting	4,000	3,147	127%
Journal Prod./Sci. Editor Serv.	9,800	7,000	140%
Journal Prod./Freelance	4,800	4,510	106%
Journal Prod./Photography	2,000	0	ERR
Journal Sales/T&A	6,600	11,624	57%
Journal Sales/Sales Mgr. Comm.	13,160	12,064	109%
Journal Sales/Tel. & Telegraph	5,300	5,195	102%
Journal Sales/Promotion	8,480	9,658	88%
Journal Sales/Agency Commission	55,000	51,149	108%
Journal Sales/Audit & Brokerage	1,590	1,041	153%
Journal Sales/Mailings	0	\$1,330	0%
Journal Sales/Bad Debts	1,000	\$8,958	11%
Total	\$675,847	\$624,456	108%

NOTES TO THE 1987 BUDGET

The following notes are intended to facilitate your review of the 1987 CDA Budget.

General

The 1987 Budget is forecast on developed activity plans, an analysis of the 1985 Financial Statements, the current year's interim financial statements, and the experience of the staff members in managing the programs.

Presentation

The budget is being presented in a format somewhat different from last year. A notable change is in the presentation of expenses, which have been summarized by project area. This presentation is intended to provide you a better understanding of the true cost of each project or council/committee area.

The front page of both the revenue and expense budgets is a summary of the attached pages.

Functional Accounting

We have continued to move in the direction of functional accounting. In full functional accounting, each department is allocated an appropriate portion of their overhead expenses. In this budget, we have so allocated staff payroll, temporary staff, and staff benefits. As a result, you will notice what appears to be a substantial increase in the line item "staff" in each department. As well, you will see a corresponding reduction in the administration budget. This may be somewhat confusing but it should only be a short-term problem. In future years the budget presentation should be easier to understand.

"ERR" Messages

In reviewing the budget, you will notice under the "1987 Budget/1986 Budget" column, several instances where the letters ERR appear. This is an indication by the computer, that an error has been made. In fact, an error has not been made. This message occurs where there is an item in the '87 budget column without a corresponding item in the '86 budget column. Hence, a number divided by zero. While mathematically an error, it was left in intentionally to show the change from one year to the next.

Meeting Costs

To simplify the calculation of Council and Committee meeting expense, a formula was used encompassing the scheduled number of meetings, the duration of those meetings in days, and the number of participating members. Cost factors of \$500 for return airfare and \$195 per night for accommodation and meals were also plugged into the formula. Using this formula, we projected the cost of the various meetings. Subsequently, staff reviewed these costs, and based on their experience, adjusted them up or down.

TAXATION COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Committee Members: Dr. Robert N. Hicks, Chairman, Vancouver
Dr. John R. Robertson, Summerside
Dr. Bradley W. Holmes, Kenora
Dr. Ron J. Markey, Vancouver

ITEMS REQUIRING BOARD ACTION

I. Canadian Dental Foundation

In our previous report, the Committee recommended that CDA investigate the possibility of creating a Foundation to which members of our profession could donate or bequest funds for the benefit of certain areas of operation of our national association. The Dental Awareness Program is one such area of operation where such a Foundation could offer financial assistance.

With legal assistance, the CDA, through its Taxation Committee, approached Revenue Canada on this issue, and to date, has received a favourable response. It is expected that the Charities Division of Revenue Canada will provide us with their ruling within the next two months.

It is the recommendation of the Taxation Committee:

RESOLVED:

87.41 THAT the Board of Governors approve the establishment of "The Canadian Dental Foundation".

ADOPTED

The report to the Executive Council on this matter is attached.

APPENDIX I

This recommendation is supported by the Council on Nominations, Awards and Trusts.

TAXATION COMMITTEE

2. Tax Reform

The federal government has identified that a white paper will be forthcoming outlining proposed methods of changing many aspects of the tax system in Canada. It has been indicated that a major overhaul of our tax system is being considered.

While encouraging predictions of reduced personal income tax rates and the elimination of the federal sales tax have been put forward by tax newsletter writers, it is evident to us all that the federal government must not just sustain existing tax revenue but must, in fact, find increased revenue if our national deficit is to be decreased. Similar to the United States of America, it is anticipated that increase in tax revenue will be sought from the business community.

A new tax that is being considered is called the Business Transfer Tax (BTT). This type of tax is also referred to in other countries as a Value Added Tax. The Minister of Finance has stated that the BTT would apply to all businesses - including those businesses that provide services. This will mean that professions such as dentistry, medicine, law, accounting, etc. will be affected by this new tax.

It has been stated that the BTT would likely be based on a percentage of sales/services (gross revenue), less the cost of purchases from other businesses. However, the deductions might not include labour or interest costs. "Labour Intensive Professional Practices such as dentists, physicians, lawyers, and accountants could be hard-hit" states one tax newsletter.

RESOLVED:

- 87.42 THAT the CDA encourage discussion of the issue of BTT by the Joint Professional Committee (Canadian Dental Association, Canadian Medical Association, Canadian Bar Association and the Canadian Institute of Chartered Accountants).

ADOPTED

In the past, presentations to the government by the Joint Professional Committee have resulted in positive change. It is important that the professions form a unified position on this issue and present their concerns in a clear and concise manner.

TAXATION COMMITTEE

RESOLVED:

- 87.43 THAT the Taxation Committee be authorized to develop a letter and/or a brief to the Minister of Finance stating CDA's opposition to the application of a proposed Business Transfer Tax on the provision of dental treatment services by dental practitioners in Canada; and,

THAT an expenditure of up to \$5,000 be approved for this project.

ADOPTED

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

3. Federal Sales Tax on Dental Materials and Orthodontic Appliances/Supplies

Following the August, 1986 Board of Governors Meeting in Halifax, the CDA received confirmation from Revenue Canada - Excise that dental materials used in reconstructive surgery, artificial teeth and articles/materials for use in the manufacture thereof, orthodontic appliances and orthodontic materials/articles used in fixed banding procedures will return to their tax exempt status. In addition, Revenue Canada ruled that local anaesthetics will be sales tax exempt.

A list of the specific materials and articles included in this decision were mailed to all CDA members and were included in the November, 1986 issue of the CDA Journal.

In the September mailing of this information to our members, the Taxation Committee identified a refund process that is available to those companies or individuals who paid the tax to Revenue Canada after July 1, 1985 (i.e. the date when the tax was applied). An article has been prepared for the February, 1987 CDA Communiqué identifying the refund process in detail.

APPENDIX II

It is evident that dental supply wholesalers (distributors), Canadian dental supply manufacturers or producers, and Canadian dental laboratories will be the "taxpayers" who are eligible for the tax refund. In some instances, the dental supply retailer may be the "taxpayer" if they imported goods directly into Canada. While these companies are entitled to the tax refunds, it is a fact that upward price adjustments were made on dental goods to recover the taxes paid by these companies.

TAXATION COMMITTEE

The CDA, through its Taxation Committee, has initiated discussions with the Dental Industry Association of Canada (DIAC) in an effort to gain return of some of these upward price adjustments to individual dentists or to the dental profession as a whole. The Communiqué article also identifies the tax refund process for those dentists who imported goods directly into Canada or who paid an additional amount identified as "federal sales tax" on invoices from dental laboratories or dental suppliers.

4. Customs Clearance Procedure

A new customs clearance procedure has been implemented which results in imported goods being delivered directly to the importer. The importer is then required to complete a form E14-2 and remit the necessary duty or taxes.

To assist our members, the Taxation Committee will be producing a list of dental goods with the appropriate tariff numbers and the percentage of duty and/or federal sales tax required. This list will be published in a future Communiqué.

5. Convention Expenses

CDA Headquarters has recently received a number of requests regarding specific information on Revenue Canada's interpretation of allowable convention expenses. In response, the Taxation Committee has produced an article on this topic for the February, 1987 CDA Communiqué.

APPENDIX II

6. Personal Services Business Definition

The Chairman of the Taxation Committee met with Mr. George Venner, Director General - Audit Programs Directorate, Revenue Canada, and Mr. Ken Warren, Special Audits Division, on December 5, 1986 to further discuss Revenue Canada's application of the personal services business definition when auditing professional management companies (PMCs).

The personal service business definition may apply to a PMC if the dentist's spouse, who has 10% or greater of the shares of the PMC, is employed by the professional management company that provides services to the dentist's practice and the PMC employs less than six (6) persons. The PSB definition results in a very punitive tax treatment of the PMC.

TAXATION COMMITTEE

Revenue Canada continued to be sympathetic and supportive of our concerns. However, they remained firm in their position that they PSB definition would be applied to PMCs if the facts dictate.

During our discussions, Revenue Canada asked if there were any specific cases where the PSB definition had been applied, since they were not aware of any. At that time, CDA did not have any cases that were reported to them. Revenue Canada stated that, if specific cases arose, they would be willing to review the issue again.

Following a request in the last CDA Communiqué for information on any PMC under audit where the PSB definition was being applied, the Taxation Committee has located a good example to further our discussions with Revenue Canada.

7. Communication of Current Tax Information

In an effort to improve the availability of tax information to the Canadian dentist, the Taxation Committee presented a proposal to the Executive Council which recommended the following:

APPENDIX III

- A. That CDA provide Tax Seminars in three different Canadian locations each year. These seminars would have professional tax advisors as lecturers.
- B. That CDA publish a tax update Newsletter that targets on tax issues related to the dentist's practice and private financial affairs.

The tax seminar proposal would be self-funding while the Tax Newsletter would create an additional cost for our Association. The Executive Council approved the establishment of CDA Tax Seminars and recommended that the existing publications of CDA (i.e. the Journal and the Communiqué) be used to circulate current tax information.

TAXATION COMMITTEE

The intent, format and financial aspects of the Tax Seminars are included in this report as Appendix IV and include the Tax Seminar information that was forwarded to the Executive Council.

APPENDIX IV

Respectfully submitted,



Robert N. Hicks, D.D.S., M.S.
Chairman - Taxation Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Taxation Committee with appreciation.

MEMORANDUM

TO: Executive Council

FROM: Dr. Robert Hicks
Chairman, Taxation Committee

DATE: January 26, 1987

SUBJECT: CANADIAN DENTAL FOUNDATION

In its 1986 Report to the Annual CDA Board of Governors meeting in Halifax, the Taxation Committee indicated that it was reviewing the present tax treatment of charities and charitable donations.

That review has been completed and has provided information that supports the development of a Charitable Foundation to which members of our profession could make tax deductible donations or bequest funds which, in turn, could benefit certain areas of interest of our national association.

In discussion with the Charities Division of Revenue Canada, such a Foundation could provide funds to support activities such as:

- Dental Awareness Program
- Lectures at CDA Conventions, Continuing Education Courses, Seminars, etc.
- Sydney Wood Bradley Memorial Library
- CDA Resource Centre
- Donations to the Canadian Fund for Dental Education

The examples given above are not meant to be exhaustive but rather are presented as representative of the calibre and type of activities which relate to encouragement of good dental health in Canada. Funds could not be used to support membership services, assistance to individual dentists, promotion of dental practices, etc.

The future benefit to the CDA would be some financial relief in our membership supported budget which attempts to operate these programs.

The establishment of a viable beneficial Foundation will take a considerable period of time. We must gain the support and acceptance of our profession in order to accumulate the funds required. We are most fortunate to have recently received two significant donations in the CDA which could be placed within the new Foundation to give it a meaningful start.

It is the recommendation of the Taxation Committee that the CDA assist in the establishment of a Charitable Organization to be known as the "Canadian Dental Foundation".

To assist the Executive Council and the Board of Governors in reaching a decision to support this recommendation, the Taxation Committee is attaching to this report two documents (Appendix A and B) required for incorporation of such a Foundation under Part II of the Canada Corporations Act. For the benefit of the Executive Council and the Board of Governors, the following are the highlights of the Application for Incorporation and the proposed By-laws of the Canadian Dental Foundation:

1. Application for Incorporation under Part II of the Corporations Act of Canada

The application provides the following information:

(a) Name of the Incorporation - Canadian Dental Foundation

- The name cannot be similar to the name of any other incorporation nor may the name be objectionable to the public.

(b) Names of the Applicants and the First Trustees

- The present Executive Council and the CDA Executive Director have been named as the Applicants and the First Trustees to facilitate the application procedure. The initial operative trustees may or may not be the Executive Council. This issue will be addressed later in this report.

(c) The Objectives of the Corporation

- (i) The prime objective of the Foundation is to raise funds to assist in the encouragement of good dental health in Canada.

(ii) To reach the prime objectives, the objects of the Foundation go further to identify:

- education of the community to encourage dental awareness, prevention of dental disease
- support and operate a library to be known as the Sydney Wood Bradley Memorial Library
- support research, lecturers, seminars, etc. to encourage the highest level of competence among Canadian dentists
- cooperate, collaborate and assist qualified donees

(iii) to solicit and receive donations, gifts and bequests.

(iv) to disburse and distribute such money and property in the furtherance of the objectives of the Foundation.

(d) Dissolution of the Foundation

- In the event that it is decided to dissolve the Foundation, it is provided that all remaining assets shall be distributed to one or more recognizable charitable organizations in Canada.

(e) Powers of the Trustees

- In addition to the powers identified in the By-laws, the Trustees, in accordance with Section 65 of the Canada Corporations Act, may borrow money upon credit of the corporation and may provide security in connection with any borrowing.

(f) Remuneration of Trustees

- The Foundation is to carry on its operation without pecuniary gain to its trustees or members.

2. By-laws of the Foundation

(a) Membership

- The Board of Trustees may create categories of membership.

- The purpose of this condition is to provide the opportunity to create a member status in the Foundation that requires an annual contribution. The intent of this purpose is to encourage Corporate contributions to the Foundation on an annual basis. The Corporate "member" may even be given the opportunity to identify their membership status, within their national advertising, to show their strong support for the objectives of the Canadian Dental Foundation. These decisions will rest with the Board of Trustees.

(b) Board of Trustees

- The initial Board of Trustees consists of ten persons and their term of office shall be one year. The Board of Trustees will amend the By-laws to specify the exact number of Trustees on the Board and ensure that the CDA Executive Director is one of the Trustees.
- Five trustees shall constitute a quorum for the purpose of a meeting.
- The CDA Board of Governors will appoint all future Trustees for a term of office not to exceed two years. A Trustee may serve for three consecutive terms of office.
- Meetings of the Board of Trustees may be held at any time providing seven days notice is provided.
- While remuneration for Trustees or Executive Management Members of the Board is not permitted, reasonable expenses for their attendance at meetings is allowed.
- The Board of Trustees may appoint agents or engage employees as necessary and such employees and agents duties, authority, and remuneration shall be fixed by the Board of Trustees by resolution.

(c) Management Committee

- There shall be a Management Committee comprising of four Trustees, one of whom shall be the CDA Executive Director, appointed by the Board of Trustees. Three persons shall constitute a quorum of the Management Committee.

(d) Amendment of By-laws

- The By-laws may be amended or repealed by an affirmative vote of two thirds (2/3) of the Trustees attending a meeting duly called for the purpose of considering the said by-law, provided thirty (30) days notice of such a meeting is given.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Robert N. Hicks".

Robert N. Hicks, D.D.S., M.S.
Chairman - Taxation Committee

BY-LAWS FOR C.C.A. PART II CORPORATION

CORPORATE SEAL

1. The seal, an impression whereof is stamped in the margin hereof, shall be the seal of the Canadian Dental Foundation.

CONDITIONS OF MEMBERSHIP

2. (a) The Board of Trustees may create categories of membership in the Foundation to carry out the objects of the corporation.
- (b) Membership in the corporation shall be limited to those persons or organizations interested in furthering the objects of the corporation and shall consist of anyone whose application for admission as a member has received the approval of the Board of Trustees of the corporation.
- (c) There shall be no membership fees or dues unless otherwise determined by the Board of Trustees and members shall have no voting power in the corporation.
- (d) Any member may withdraw from the corporation by delivering to the corporation a written resignation and lodging a copy of the same with the secretary of the corporation.
- (e) Any member may be required to resign by a vote of three-quarters (3/4) of the Trustees.

HEAD OFFICE

3. The Head Office of the Corporation shall be located at:
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

BOARD OF TRUSTEES

4. (a) The property and business of the corporation shall be managed by the Board of Trustees of whom five (5) shall constitute a quorum.
- (b) The applicants for incorporation shall become the first Trustees of the corporation whose term of office shall be one year.

- (c) The Board of Trustees of the corporation shall be appointed by the Board of Governors of the Canadian Dental Association and the Trustees so appointed shall replace the provisional Trustees named in the Letters Patent of the corporation.
- (d) The Trustees so appointed will serve for a term of office not to exceed two years. A Trustee may serve three consecutive terms of office.
- (e) The office of Trustee shall be automatically vacated:
 - (i) if a Trustee shall resign his office by delivering a written resignation to the secretary of the corporation;
 - (ii) if a Trustee is found to be a lunatic or becomes of unsound mind;
 - (iii) if a Trustee becomes bankrupt or suspends payment or compounds with his creditors;
 - (iv) if at a special general meeting of Trustees a resolution is passed by three-quarters ($3/4$) of the Trustees present at the meeting that a Trustee be removed from office;
 - (v) on death;

provided that if any vacancy shall occur for any reason in this paragraph contained, the Executive Committee of the Canadian Dental Association, by majority, may fill the vacancy for the duration of the term of office.
- (f) Meetings of the Board of Trustees may be held at any time and place to be determined by the Trustees provided that seven (7) clear days notice of such meeting shall be sent in writing to each Trustee, provided there shall be at least one (1) meeting per year of the Board of Trustees. No error or omission in giving notice of any meeting of the Board of Trustees or any adjourned meeting of the Board of Trustees of the corporation shall invalidate such meeting or make void any proceedings taken thereat and any Trustee may at any time waive notice of any such meeting and may ratify, approve and confirm any or all proceedings taken or had thereat. Each Trustee is authorized to exercise one (1) vote.
- (g) Trustees and executive management members, as such, shall not receive any stated remuneration for their services, but, by resolution of the Board of Trustees, expenses of their attendance may be allowed for their attendance at each regu-

lar or special meeting of the Board of Trustees. Nothing herein contained shall be construed to preclude any Trustee from serving the corporation as an officer or in any other capacity. No Trustee shall directly or indirectly receive any profit from his position as such; provided that a Trustee may be paid reasonable expenses incurred by him in the performance of his duties as an officer or agent of the corporation.

- (h) A retiring Trustee shall remain in office until the dissolution or adjournment of the meeting at which his retirement is accepted and his successor is elected. A Trustee shall hold office until the next annual meeting of Trustees following his election or appointment.
- (i) The Board of Trustees may appoint such agents and engage such employees as it shall deem necessary from time to time and such persons shall have such authority and shall perform such duties as shall be prescribed by the Board of Trustees at the time of such appointment.
- (j) The remuneration of all officers, agents and employees and committee members shall be fixed by the board of Trustees by resolution.

INDEMNITIES TO TRUSTEES AND OTHERS

5. Every Trustee or officer of the corporation or other person who has undertaken or is about to undertake any liability on behalf of the corporation or any company controlled by it and their heirs, executors and administrators, and estate and effects, respectively, shall from time to time and at all times, be indemnified and saved harmless out of the funds of the corporation, from and against;
- a) all costs, charges and expenses which such Trustee, officer or other person sustains or incurs in or about any action, suit or proceedings which is brought, commenced or prosecuted against him, or in respect of any act, deed, matter or thing whatsoever, made, done or permitted by him, in or about the execution of the duties of his office or in respect of any such liability;
 - b) all other costs, charges and expenses which he sustains or incurs in or about or in relation to the affairs thereof, except such costs, charges or expenses as are occasioned by his own wilful neglect or default.

MANAGEMENT COMMITTEE

6. (a) There shall be a management committee comprising of four Trustees, one of whom shall be the CDA Executive Director, who shall be appointed by the Board of Trustees and which committee shall exercise such powers as are authorized by the Board of Trustees. Any management committee member may be removed by a majority vote of the Board of Trustees.
- (b) Meetings of the management committee shall be held at any time and place to be determined by the members of such committee provided that forty-eight (48) hours notice of such meeting shall be sent in writing to each member of such committee. Three members of such committee shall constitute a quorum, one of whom must be the CDA Executive Director. No error or omission in giving notice of any meeting of the management committee or any adjourned meeting of the management committee of the corporation shall invalidate such meeting or make void any proceedings taken thereat and any member of such committee may at any time waive notice of any such meeting and may ratify, approve and confirm any or all proceedings taken or had thereat.

POWERS OF TRUSTEES

7. (a) The Trustees of the corporation may administer affairs of the corporation in all things and make or cause to be made for the corporation, in its name, any kind of contract which the corporation may lawfully enter into and, save as hereinafter provided, generally, may exercise all such other powers and do all such other acts and things as the corporation is by its charter or otherwise authorized to exercise and do.
- (b) The Trustees shall have power to authorize expenditures on behalf of the corporation from time to time and may delegate by resolution to an officer or officers of the corporation the right to employ and pay salaries to employees. The Trustees shall have the power to make expenditures for the purpose of furthering the objects of the corporation. The Trustees shall have the power to enter into a trust arrangement with a trust company for the purpose of creating a trust fund in which the capital and interest may be made available for the benefit of promoting the interest of the Canadian Dental Foundation in accordance with such terms as the Board of Trustees may prescribe.

- (c) The Board of Trustees shall take such steps as they may deem requisite to enable the corporation to acquire, accept, solicit or receive legacies, gifts, grants, settlements, bequests, endowments and donations of any kind whatsoever for the purpose of furthering the objections of the corporation.

OFFICERS

- 8. (a) The officers of the corporation shall be a president, vice-president, secretary and treasurer and any such other officers as the Board of Trustees may by by-law determine. Any two offices may be held by the same person.
- (b) The president shall be elected at the annual meeting of the Trustees. Officers other than president of the corporation shall be appointed by resolution of the Board of Trustees at the first meeting of the Board of Trustees following each annual meeting of the Trustees.
- (c) The officers of the corporation shall hold office for one (1) year from the date of appointment or election or until their successors are elected or appointed in their stead. Their term of office may be renewed.
- (d) All officers shall be Trustees of the corporation and they shall cease to be officers if they cease to be Trustees or if they are removed by a majority of the Board of Trustees.

DUTIES OF OFFICERS

- 9. (a) The president shall be the chief executive officer of the corporation. He shall preside at all meetings of the corporation and of the Board of Trustees. He shall have the general and active management of the affairs of the corporation. He shall see that all orders and resolutions of the Board of Trustees are carried into effect.
- (b) The vice-president shall, in the absence or disability of the president, perform the duties and exercise the powers of the president and shall perform such other duties as shall from time to time be imposed upon him by the Board of Trustees.
- (c) The treasurer shall have the custody of the funds and securities of the corporation and shall keep full and accurate accounts of all assets, liabilities, receipts and disbursements of the corporation in the books belonging to the cor-

poration and shall deposit all monies, securities and other valuable effects in the name and to the credit of the corporation in such chartered bank or trust company, or, in the case of securities, in such registered dealer in securities as may be designated by the Board of Trustees from time to time. He shall disburse the funds of the corporation as may be directed by proper authority taking proper vouchers for such disbursements, and shall render to the president and Trustees at the regular meeting of the Board of Trustees, or whenever they may require it, an accounting of all the transactions and a statement of the financial position, of the corporation. He shall also perform such other duties as may from time to time be directed by the Board of Trustees.

- (d) The secretary may be empowered by the Board of Trustees, upon resolution of the Board of Trustees, to carry on the affairs of the corporation generally under the supervision of the officers thereof and shall attend all meetings and act as clerk thereof and record all votes and minutes of all proceedings in the books to be kept for that purpose. He shall give or cause to be given notice of all meetings of the members and of the Board of Trustees, and shall perform such other duties as may be prescribed by the Board of Trustees or president, under whose supervision he shall be. He shall be custodian of the seal of the corporation, which he shall deliver only when authorized by a resolution of the Board of Trustees to do so and to such person or persons as may be named in the resolution.
- (e) The duties of all other officers of the corporation shall be such as the terms of their engagement call for or the Board of Trustees requires of them.

EXECUTION OF DOCUMENTS

- 10. Contracts, documents or any instruments in writing requiring the signature of the corporation, shall be signed by any two officers and all contracts, documents and instruments in writing so signed shall be binding upon the corporation without any further authorization or formality. The Trustees shall have power from time to time by resolution to appoint an officer or officers on behalf of the corporation to sign specific contracts, documents and instruments in writing. The Trustees may give the corporation's power of attorney to any registered dealer in securities for the purposes of the transferring of and dealing with any stocks, bonds, and other securities of the corporation. The seal of the corporation when required may be affixed to contracts, documents and

instruments in writing signed as aforesaid or by any officer or officers appointed by resolution of the Board of Trustees.

MEETINGS

11. (a) The annual or any other general meeting of the Trustees shall be held at the head office of the corporation or at any place as the Board of Trustees may determine and on such day as the said Trustees or their management committee shall appoint.
- (b) At every annual meeting, in addition to any other business that may be transacted, the report of the president, the financial statement and the report of the auditors shall be presented and officers elected and auditors appointed for the ensuing year. The members may consider and transact any business either special or general at any meeting of the members. The Board of Trustees or the president or vice-president shall have power to call, at any time, a general meeting of the Trustees of the corporation.
- (c) Fourteen (14) days' prior written notice shall be given to each Trustee of any annual or special general meeting of Trustees. Trustees present in person at a meeting shall constitute a quorum. Each Trustee present at a meeting shall have the right to exercise one vote.
- (d) No error or omission in giving notice of any annual or general meeting or any adjourned meeting, whether annual or general, of the Trustees of the corporation shall invalidate such meeting or make void any proceedings taken thereat and any Trustee may at any time waive notice of any such meeting and may ratify, approve and confirm any or all proceedings taken or had thereat. For purpose of sending notice to any Trustee or officer for any meeting or otherwise, the address of the member, Trustee or officer shall be his last address recorded on the books of the corporation.

MINUTES OF BOARD OF TRUSTEES AND MANAGEMENT COMMITTEES

12. The minutes of the Board of Trustees or the minutes of the management committee shall not be available to the general membership of the corporation but shall be available to the Board of Trustees, each of whom shall receive a copy of such minutes.

VOTING OF MEMBERS

13. At all meetings of members of the corporation every question shall be determined by a majority of votes unless otherwise specifically provided by statute or by these by-laws.

FINANCIAL YEAR

14. (a) Unless otherwise ordered by the Board of Trustees the fiscal year-end of the corporation shall be the calendar year.
- (b) The Board of Trustees may appoint committees whose members will hold their offices at the will of the Board of Trustees.

AMENDMENT OF BY-LAWS

15. The by-laws of the corporation not embodied in the letters patent may be repealed or amended by by-law enacted by a majority of the Trustees at a meeting of the Board of Trustees and sanctioned by an affirmative vote of at least two-thirds (2/3) of the members at a meeting duly called for the purpose of considering the said by-law, provided that the repeal or amendment of such by-laws shall not be enforced or acted upon until the approval of the Minister of Consumer and Corporate Affairs has been obtained. Notice of Motion for a by-law amendment must be delivered to each Trustee 30 days before the date of the meeting at which the by-law amendment is to be considered.

AUDITORS

16. The Trustees shall at each meeting appoint an auditor to audit the accounts of the corporation to hold office until the next annual meeting provided that the Trustees may fill any casual vacancy in the office of auditor. The remuneration of the auditor shall be fixed by the Board of Trustees.

BOOKS AND RECORDS

17. The Trustees shall see that all necessary books and records of the corporation required by the by-laws of the corporation

or by any applicable statute or law are regularly and properly kept.

RULES AND REGULATIONS

18. The Board of Trustees may prescribe such rules and regulations not inconsistent with these by-laws relating to the management and operation of the corporation as they deem expedient, provided that such rules and regulations shall have force and effect only until the next annual meeting of the Trustees of the corporation when they shall be confirmed, and failing such confirmation at such annual meeting of Trustees shall at and from time to time cease to have any force and effect.

INTERPRETATION

19. In these by-laws and in all other by-laws of the corporation hereafter passed unless the context otherwise requires, words importing the singular number or the masculine gender shall include the plural number or the feminine gender, as the case may be, and vice versa, and references to persons shall include firms and corporations.

IN WITNESS WHEREOF we have hereunto set our hands at _____ on the _____ day of _____, 198__.

SIGNED, SEALED and DELIVERED)
by J.R. Robertson in the)
presence of:)

Signature)

Name)

Address)

Occupation)

J.R. ROBERTSON

SIGNED, SEALED and DELIVERED
by R.J. MARKEY, in the
presence of:

Signature

Name

Address

Occupation

R.J. MARKEY

SIGNED, SEALED and DELIVERED
by B.W. Holmes in the presence
of:

Signature

Name

Address

Occupation

B.W. HOLMES

SIGNED, SEALED and DELIVERED
by D.E. MacFarlane in the
presence of:

Signature

Name

Address

Occupation

D.E. MacFARLANE

SIGNED, SEALED and DELIVERED)
by E.F. Allison in the presence)
of:)

Signature)

Name)

E.F. ALLISON)

Address)

Occupation)

SIGNED, SEALED and DELIVERED)
by J.W. Niedermayer in the)
presence of:)

Signature)

Name)

J.W. NIEDERMAYER)

Address)

Occupation)

SIGNED, SEALED and DELIVERED)
by K.L. Roach in the presence)
of:)

Signature)

Name)

K.L. ROACH)

Address)

Occupation)

SIGNED, SEALED and DELIVERED)
by G. Dube in the presence)
of:)

Signature)

Name)

Address)

Occupation)

G. DUBE

SIGNED, SEALED and DELIVERED)
by J. Christie in the presence)
of:)

Signature)

Name)

Address)

Occupation)

J. CHRISTIE

SIGNED, SEALED and DELIVERED)
by J. Neilson in the presence)
of:)

Signature)

Name)

Address)

Occupation)

J. NEILSON

APPENDIX B

APPLICATION FOR INCORPORATION OF A CORPORATION WITHOUT SHARE
CAPITAL UNDER PART II OF THE CANADA CORPORATIONS ACT

To the Minister of Consumer and Corporate Affairs of Canada.

I

The undersigned hereby apply to the Minister of Consumer and Corporate Affairs for the grant of a charter by letters patent under the provisions of Part II of the Canada Corporations Act constituting the undersigned, and such others as may become members of the Corporation thereby created, a body corporate and politic under the name of

Canadian Dental Foundation

The undersigned have satisfied themselves and are assured that the proposed name under which incorporation is sought is not the same or similar to the name under which any other company, society, association or firm, in existence is carrying on business in Canada or is incorporated under the laws of Canada or any province thereof or so nearly resembles the same as to be calculated to deceive except that of the Canadian Research Foundation and the Canadian Dental Association L'association Dentaire Canadienne which have both signified their consent to the use of the said name and that it is not a name which is otherwise on public grounds objectionable.

II

The applicants are individuals of the full age of eighteen years with power under law to contract. The name, the address and the calling of each of the applicants are as follows:

J.R. Robertson, Dentist	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
R.J. Markey, Dentist	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
B.W. Holmes	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6

D.E. MacFarlane	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
E.F. Allison	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
J.W. Niedermayer	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
K.L. Roach	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
G. Dube	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
J. Christie	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6
J. Neilson, Executive Director	1815 Alta Vista Drive Ottawa, Ontario K1G 3Y6

The said applicants will be the first Trustees of the Corporation.

III

The objects of the Corporation are:

- (a) To create and operate a fund to be used to assist in the encouragement of good dental health in Canada including the promotion of high levels of technical competence among dentists.
- (b) To educate the community at large in the following:
 - (i) to encourage the awareness and importance of good dental health.
 - (ii) to encourage the prevention of dental diseases.

- 3 -

- (iii) to encourage treatment of existing dental disease in order to prevent the loss of teeth and supporting tissue.
- (c) To support and operate a library to be known as the Sydney Wood Bradley Memorial Library whose focus will be devoted to works of concern to dentists and other dental health care professionals.
- (d) To encourage the highest level of competence amongst Canadian dentists through the support of research, lecturers, seminars and other similar programs.
- (e) To co-operate, collaborate with and assist qualified donees.
- (f) To solicit, receive and hold donations, gifts, devises and bequests for the objects of the Foundation.
- (g) To disperse and distribute such money and property in the furtherance of the objects of the Foundation.

IV

The operations of the Corporation may be carried on throughout Canada and elsewhere.

V

The place within Canada where the head office of the Corporation is to be situated is:

c/o The Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

VI

It is specially provided that in the event of dissolution or winding-up of the Corporation all its remaining assets after payment

of its liabilities shall be distributed to one or more recognized charitable organizations in Canada.

VII

In accordance with Section 65 of the Canada Corporations Act, it is provided that, when authorized by by-law, duly passed by the trustees and sanctioned by at least two-thirds of the votes cast at a special general meeting of the trustees duly called for considering the by-law, the trustees of the Corporation may from time to time

- a) borrow money upon credit of the Corporation in such manner as may be desirable for the purpose of carrying out the objects of the Corporation;
- b) limit or increase the amount to be borrowed; and
- c) provide security in connection with any borrowing, by mortgage, hypothec, charge or pledge of all or any currently owned or subsequently acquired real and personal, movable and immovable, property of the Corporation, and the undertaking and rights of the Corporation.

Any such by-law may provide for the delegation of such powers by the trustees to such officers or trustees of the Corporation to such extent and in such manner as may be set out in the by-law.

Nothing herein limits or restricts the borrowing of money by the Corporation on bills of exchange or promissory notes made, drawn, accepted or endorsed by or on behalf of the Corporation.

VIII

The by-laws of the Corporation shall be those filed with the application for letters patent until repealed, amended, altered or added to.

IX

The Corporation is to carry on its operation without pecuniary gain to its trustees or members and any profits or other accretions to the Corporation are to be used in promoting its objects.

- 5 -

DATED at the City of Ottawa, in the Province of Ontario, this
_____ day of _____, 1986.

J.R. ROBERTSON

R.J. MARKEY

B.W. HOLMES

D.E. MacFARLANE

E.F. ALISON

J.W. NIEDERMAYER

K.L. ROACH

G. DUBE

J. CHRISTIE

J. NEILSON

CANADIAN DENTAL ASSOCIATION Communiqué

February, 1987

APPENDIX II

A CDA Member Service

As you know, as of August 22, 1986, federal sales tax has been removed from the following goods which had been taxed since July 1, 1985:

- 1) Dental Articles and Materials Used in the Manufacture of Artificial Teeth (Excise Tax Act, Schedule III, Part VIII, Section 5)
- 2) Dental Materials Used in Reconstructive Surgery (Excise Tax Act, Schedule III, Part VIII, Section 19)
- 3) Orthopaedic Appliances, Orthodontic Appliances, Retaining or Maintaining Appliances, and Habit Breaker Appliances (Excise Tax Act, Schedule III, Part VIII, Section 18)
- 4) Fixed Banding Appliances (Excise Tax Act, Schedule III, Part VIII, Section 19)

Lists of the specific goods involved in these Excise Tax Act Sections have been mailed to you and were published in the November issue of the CDA Journal. If additional copies of these lists are required, they may be obtained from the CDA Headquarters. In addition, the goods ruled upon appear in the ruling database of Revenue Canada as rulings 7315/60, 7315/61, 7355/8 and 7355/9.

Federal sales tax was applied to these goods as a result of the May, 1985 Federal Budget and the tax came into effect on July 1, 1985. The tax was required on the aforementioned goods when manufactured/produced in or imported into Canada as of that date. The tax was paid by the following individuals:

C A L L



THE PRESIDENT

D A Y

This is your opportunity to voice your questions, concerns and suggestions. Call President John Robertson on Tuesday, February 10th, 8:30 a.m. to 4:30 p.m. EST. (613) 523-1770 (collect)

FEDERAL SALES TAX REFUND PROCEDURE

a) Manufacturers or producers of the dental goods in Canada licensed for the purpose for the Excise Tax Act, including:

- licensed manufacturers or producers of dental goods who paid to Revenue Canada the tax on the sale prices of the goods to their customers, i.e. dental supply wholesalers, distributors, retailers, individual dental laboratories, individual dentists, or Professional Management Companies (PMCs);
- licensed dental laboratories who paid to Revenue Canada the tax on the sale prices of the goods to their customers (i.e. dentists or PMCs).

b) Wholesalers licensed for the purpose of the Excise Tax Act.

c) Those importing the goods into Canada:

- Dental supply wholesalers, distributors and retailers who paid the tax to Revenue Canada on the duty paid value of the imported goods.
- Dental laboratories who paid the tax to Revenue Canada on the duty paid value of the imported goods.
- Individual dentists or PMCs who paid the tax to Revenue Canada on the duty paid value of the imported goods.

The tax paid on these goods by the companies or individuals identified above, other than the dentist or the

(cont'd. on page 2)

The CDA Communiqué is published as a news and information service to members of the Canadian Dental Association.

Direct all enquiries to:
 Kimberley Allen
 Information Officer
 Canadian Dental Association
 1815 Alta Vista Drive
 Ottawa, Ontario K1G 3Y6
 (613) 523-1770



Items in Communiqué

- Tax Information on Convention Expenses
- CDA Announces Taxation Seminars
- CDA Standard Dental Referral Form
- DAP Update

(Refund cont'd.)

PMC who imported the goods directly into Canada, is usually passed on to the end-consumer (the dentist or the PMC) and reflected in the selling price to the end-user in one of two ways:

- a) An upward price adjustment of the goods sold to the dentist or the PMC; or
- b) An additional item on the invoice to the dentist or the PMC, identified as federal sales tax.

For the dentist or the PMC importing goods directly into Canada, the federal sales tax is paid to Revenue Canada by the dentist or the PMC at the time the goods clear customs.

Tax Refund Process

When a change in Revenue Canada rulings occurs, such as the change in rulings on certain dental goods which we have experienced, the company or individual who paid the tax to the federal government, the "taxpayer", (i.e. the licensed manufacturer, licensed wholesaler/distributor or importer), is entitled to recover the taxes paid. This tax refund is achieved by making application to the Excise Branch (Canadian Goods) utilizing a form N 15 or to Canadian Customs (Imported Goods) utilizing a form B2R, within two (2) years of when the tax was paid — in our instance starting from July 1, 1985. In effect, forms N 15 or B2R request refund of taxes paid in error **after July 1, 1985**.

If the application is made after July 1, 1987, the "taxpayer" is still eligible to request a refund for taxes paid, but the refund period would be limited to the two (2) year period prior to the date the N 15 or B2R application is made. Application after July 1, 1987 may result in less than the total taxes paid being eligible for refund.

If the importer or licensed manufacturer, producer or wholesaler of the goods, or the dental laboratory (the "taxpayer") applies for and receives a refund of federal sales tax paid from Revenue Canada, there is absolutely no legal requirement that the company or the individual pass this refund on to the end-consumer (the dentist or PMC). Only the original "taxpayer" is legally entitled to the

refund, even though there may have been an upward price adjustment to the goods sold, in order to recover the original taxes paid. The individual dental trade industries, manufacturers and laboratories will decide individually, within company policy, whether a price adjustment to the end-consumer (the dentist or the PMC) will be made as a result of sales tax paid in error but recovered from Revenue Canada by way of refund.

A group of manufacturers and distributors of dental goods has recently brought to the attention of Revenue Canada officials, the CDA letter which announced the removal of federal sales tax on these dental goods, in order to bring Revenue Canada's attention to the fact that CDA's initial, simplified identification of the refund process was "technically incorrect". In that letter, we stated that "Consultation with dental suppliers and dental laboratories is necessary if dental practitioners wish to recover taxes paid." This sentence should more accurately have read "Consultation with dental suppliers and dental laboratories is necessary if practitioners wish to seek any retro-active price adjustments from their suppliers or laboratories, as a result of the aforementioned ruling." I trust this article clarifies the issue.

In summary, if taxes paid by the dentists or PMCs upon goods imported by them, or shown extra on invoices to the dentists or PMCs or upward price adjustments to the dentists or PMCs to offset the cost of taxes paid on goods purchased are to be recovered, the following procedures may be followed:

1. Where dentists or PMCs have imported goods directly into Canada:

- Application to Revenue Canada — Customs utilizing a form B2R supported by initial customs clearance documents and invoices. The assistance of a customs broker would be advantageous.

2. Where dentists or PMCs have purchased goods from suppliers or laboratories and the federal sales tax was specifically applied on their invoices:

- Consultation with and/or written application to the supplier/laboratory is necessary. Copies of invoices identifying the items may be

required. The request to the supplier/laboratory for a credit of the amount shown as extra, attributable to federal sales tax, or an adjustment to future pricing of goods would, of course, be conditional on the fact that the supplier/laboratory has applied for and received such tax refund from Revenue Canada.

3. Where dentists have purchased goods from suppliers or laboratories, and upward price adjustments have been made to recover the supplier/laboratory increased tax cost:

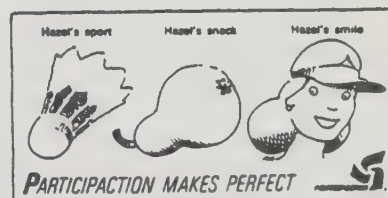
- Consultation with and/or written application to the supplier/laboratory requesting information regarding their company's policy with respect to credits or future price adjustments, in the event that they apply for and receive a tax refund from Revenue Canada.

Item 3 is a complex and complicated procedure for the dental trade industry and laboratory to work out. The CDA has initiated discussions with the Dental Industries Association of Canada, in an effort to reach an agreeable solution to this problem.

Revenue Canada — Excise has informed CDA that any application for tax refunds is usually processed within a 60 day period, if proper documentation is provided. If the processing time is longer than 60 days, interest will commence to accrue and will be added to the refund.

If additional information is required, please contact CDA Headquarters (Mrs. Sandra Deziel (613) 523-1770) or the CDA Taxation Committee Chairman (Dr. Robert Hicks (604) 922-0111). 

This article was written for the Communique by Dr. Robert Hicks, Chairman, CDA Taxation Committee.



TAX INFORMATION ON CONVENTION EXPENSES

Dental practitioners, who are self-employed, may deduct, for the purpose of computing net professional income, all reasonable expenses incurred while attending **any two conventions** which relate to their professional practice within a specific taxation year. There is no restriction on these two conventions as to whether they are sponsored by Canadian business or professional organizations, or business or professional organizations located outside of Canada.

The Income Tax Act — Part I permits this deduction in Section 20 (10), which states:

"There may be deducted in computing a taxpayer's income for a taxation year from a business an amount paid ... in the year or on account of expenses incurred by him attending in connection with the business, not more than two conventions held during the year by a business or professional organization at a location ... that may reasonably be regarded as consistent with the territorial scope of that organization."

Interpretation Bulletin IT-131R (February 28, 1986) is published by Revenue Canada to provide taxpayers with information on the current interpretation used by the department when applying Section 20 (10) of the Act.

For **self-employed individuals**, including self-employed dentists, the Bulletin includes the following information:

1. It is not necessary that the taxpayer be a member of the organization sponsoring the convention but the convention must be related to the business or professional practice carried on by the taxpayer.
2. In Canada, expenses may only be deducted when the convention is located within the territorial scope (national, provincial, municipal, or local area) of the sponsoring Canadian organization. An ocean cruise is considered to be held outside of Canada.

Outside of Canada, expenses may be deducted if the convention is

located within the territorial scope (area or country) of the sponsoring organization and is related to the taxpayer's business or professional practice.

3. Effective December 31, 1984, expenses may be deducted for attending a convention that is located in the United States but is sponsored by a Canadian business or professional organization that is **national in character**.
4. A taxpayer who combines attendance at a convention, wherever it is, with a vacation trip must allocate expenses on some reasonable basis to eliminate those that are essential for vacation purposes. For example, acceptable expenses would be full cost of return travel expenses (transportation, meals, accommodation en route) by the most direct route and the cost and accommodation while participating in the convention. Expenses incurred by or for a spouse or children accompanying the taxpayer to a convention, or convention/vacation are normally considered as personal and are not deductible.

The Bulletin also provides information that applies to employees. In our case those employees may be employees of a dental practice, employees of a professional management company, employees of a professional corporation or salaried dentists. For these **employed persons**, the Bulletin includes the following information:

1. When an employer requires an employee to attend a convention as part of the duties of employment, and the employee is **reimbursed** for reasonable cost incurred, such reimbursement would not normally be considered as income in the hands of the employee. However, if the employer gives the employee a non-accountable allowance for cost incurred to attend a convention, the employee will, as a rule, be taxable on that allowance.
2. If an employer requests that an employee's spouse accompany the employee in order to assist in

attaining the business objectives of the trip, any payment or reimbursement by the employer of the spouse's expenses is not considered as a taxable benefit to the employee.

It is important to know as an employer, that a dentist, a professional management company or a professional corporation must structure payment of convention expenses on behalf of an employee in the manner outlined in IT-357R or the employee **may** be required to claim the expenses paid on their behalf as an employee benefit. Such employee benefits are considered income by Revenue Canada and become taxable in the employee's hands.

For **corporations**, including professional management companies and professional corporations, the Bulletin provides the following additional information:

1. Where the rules of a particular convention allow a corporation to register at the convention regardless of who its officers may be, a corporation can "attend" a convention through one or more of its agents or employees. A corporation will generally be subject to the usual limitation of two conventions per year in connection with its business but may send more than one representative to each. If a corporation has diversified business interests, and many employees, the limit of two conventions per year may apply to each interest.
2. Intra-company meetings, seminars, courses, etc., are not regarded as conventions as far as employees are concerned.

Revenue Canada makes a distinction between conventions and continuing education courses or meetings, seminars, courses, etc., of groups of employees/groups of owners of a business. Conventions are defined as a formal meeting of members for professional or business purposes. The format is normally not that of a classroom. The convention does not become a continuing education

(cont'd. on page 4)

(Expenses cont'd.)

course when **some** of its sessions take the form of workshops or lectures. A continuing education course generally has a classroom format and those attending are there for the purpose of learning a subject in accordance with a formal syllabus. It is a question of fact whether a "seminar" is a convention or a training course.

Specific information on the difference between training courses and conventions is located in Interpretation Bulletin IT-357R (May 21, 1980).

Copies of IT-131R — Convention Expenses and IT-357R — Expenses of Training can be obtained from your regional Revenue Canada — Taxation Office or from Revenue Canada — Taxation, 88 Metcalfe St., Room 200, Ottawa K1A 0L8 — Attention: Aline Nault. 📞

This article was written for the Communiqué by Dr. Robert Hicks, Chairman, CDA Taxation Committee.

CFDE APPOINTS EXECUTIVE SECRETARY

The Canadian Fund for Dental Education recently moved its headquarters to Ottawa. CFDE is now housed in the CDA Building. The address is:

CFDE

Suite 105
1815 Alta Vista Drive
Ottawa, Ontario K1G 3Y6
Telephone: (613) 731-0493

Coincident with the move, Ms. Janice Forsythe was appointed Executive Secretary. In addition to her duties with CFDE, Janice also works as Coordinator of several CDA Councils and Committees.

Janice comes to CFDE with a strong background in association management. From 1979 to 1983 she worked in the Accreditation Department of the Canadian Medical Association, before moving on to become the Executive Director of the Canadian Junior Chamber/Jaycees from 1984 to 1986. Janice is looking forward to the challenge of developing an active marketing plan for the Canadian Fund for Dental Education. 📞

CDA Acts on Dental Manpower

In the fall of 1985, the CDA sponsored a National Manpower Symposium, the conclusion of which saw your national association mandated to review and take action with regard to dental professional resource utilization. The CDA Professional Resource Utilization Committee (PRUC) was then established to study the present and future resource situation, and to present recommendations to the CDA membership at large, the Association of Canadian Faculties of Dentistry, the Canadian Dental Hygienists' Association, and Health and Welfare Canada.

Major activities of the Committee during 1986 involved re-examination and re-affirmation of the conclusions of the Dental Manpower Studies conducted by R.K. House and Associates for the CDA in 1982 and 1984, and the sponsoring of a study on the demand for dental care through to the year 2006. These supply and demand figures project a future oversupply of dental professional resources, if action is not taken to adjust current supply norms.

To facilitate the next stage of the Committee's work, one of consultation and communication, a meeting with the Deans of all Canadian dental faculties, the ACFD, and the CDHA was held in Montreal on January 10, 1987. The general consensus reached was that a very real dental professional resource problem exists in Canada today. Unanimous agreement was reached by the deans of all Canadian dental faculties that a substantial reduction in the professional output of dental schools is required. The CDA will sponsor a follow-up meeting of the deans, which will focus on the delineation of an action plan for reduction in enrolment for the 1988-89 academic year.

The CDA has accepted the responsibility for communicating all critical information surrounding these decisions to the political level. As well, a summary of the supply/demand report will be sent to the Federal/Provincial Committee on Health Human Resources, to facilitate

communication with provincial ministers of health and the federal government.

The CDA is cognizant of its responsibility in this area and will continue to work through the PRUC to facilitate the search for solutions. The Committee plans to present a full report with recommendations to the Interim Meeting of the CDA Board of Governors in April, 1987.

Look for published reports on "Estimating Future Dental Care Requirements: The Implications for Dental Manpower", and a report on supply/demand forecasts, in the February and March issues of the CDA Journal. 📞

CDA STANDARD DENTAL REFERRAL FORM

The CDA Council on Health Care has produced a "Standard Dental Referral Form" for use by General Practitioners. A sample of the form appears on the following page.

You will note that this is a simple form designed to ease communication between general practitioners and specialists. Dentists are advised, as with all other forms, to keep a copy for their records. It is also important to note that the referral form is not meant to replace telephone and face to face communication, but rather, to enhance it.

We have reproduced this form here so that you may simply photocopy it and use it in your office. If, however, you would like a better quality copy which you may take to a printer and have printed in bulk, just send a cheque for \$10.00 (payable to the Canadian Dental Association) to Ms. Janice Forsythe, Coordinator, Council on Health Care, CDA, 1815 Alta Vista Drive, Ottawa, Ontario K1G 3Y6. Telephone orders will be accepted with a valid Visa or Mastercard number. Call (613) 523-1770. All orders must be prepaid. 📞

Dear Dr. _____

We are referring:

PATIENT: _____ BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: BUS. _____ RES. _____

REASON FOR REFERRAL:

☐ **CONSULTATION** RE: _____

☐ **TREATMENT** (as requested)

(Please provide specialist with appropriate details of problem, i.e. urgency, areas of concern, using F.D.I. tooth numbering system).

RELEVANT HISTORY:

(Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment).

☐ PLEASE CALL THE PATIENT

☐ PATIENT WILL CALL

☐ AN APPOINTMENT HAS BEEN MADE

☐ RADIOGRAPHS ENCLOSED

☐ PLEASE RETURN RADIOGRAPHS AFTER USE

☐ NOTIFY ON COMPLETION

☐ PLEASE REPORT - WRITTEN

☐ - PHONE

☐ POST REFERRAL MAINTENANCE - ☐ BY SPECIALIST

☐ IN THIS OFFICE

☐ TO BE DISCUSSED

☐ OTHER RECORDS AVAILABLE

DATE _____

SIGNED _____

ARE DENTAL FEES TOO HIGH?

Do your patients complain about your fees? Do you sometimes feel that you might have more patients, if dental costs were not seen to be so high?

The high cost of dental care is becoming an increasing problem for dentists. Not only do patients complain, but the companies which carry their dental plans are also keen to find ways to improve their bottom lines. One of the ways they are doing this is by signing up patients and dentists for alternative delivery dental plans, such as capitation. Capitation type schemes are sold to corporate employers, mainly on the basis that their dental benefit costs will be reduced. However, the CDA Third Party Dental Plans Committee is convinced that while the capitation type approach could lower costs, it would be at the expense of patient care. Nevertheless, the means to lowering dental benefit expenses must be found. Some suggestions follow below:

- Insurance carriers long ago discovered that costs are dramatically cut when assignment is eliminated. You can help preserve fee-for-service dentistry, and help keep costs down, by saying **NO** to assignment.
- Another way the dentist can lower costs is to offer "package deals" to patients covering a grouping of treatment services such as recall exam, prophylaxis, scaling, and fluoride if necessary. It has been suggested that a 30% package reduction could increase patient flow, and decrease dental benefit costs.

It has been brought to the attention of the Third Party Dental Plans Committee that some dentists have already experimented with such an approach, and have had claims rejected by the carrier because of the absence of an appropriate "code" for such a package. The Committee will recommend approval of such codes to the next meeting of the Board of Governors.

- Offering a 10% general discount to senior citizens has also been suggested as a means of lowering the cost of dentistry. This approach might very well attract patients who, traditionally, do not visit the dentist on a regular basis.

These are just some suggested responses to a growing problem facing dentistry today. If you are aware of others, or if you would like

to comment on this issue, please write to Ms. Janice Forsythe, Coordinator, Third Party Dental Plans Committee, CDA, 1815 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6. 



POLICY MANUAL UNDER REVISION

The "CDA Prepaid Dental Plans Policy Manual — Guide to Completing Dental Claim Forms" is currently being revised. The Third Party Dental Plans Committee has recently sent a draft to each of the Provincial Corporate Bodies for review. Once comments have been received and integrated into the document, the Committee plans to present it to the 1987 Board of Governors meeting in September for approval. Until such time as approval has been received from the Board, members should continue to use the 1979 version of

the Manual, noting that the section on the Standard Dental Claim Form has become outdated since the new form went into effect January 1, 1987.

It has been brought to our attention that some dentists are not clear on where to sign the claim form. The office verification box is for the signature of the dentist or of a designated employee or a stamp (in provinces where this is allowed). Please refer to the last issue of the Communiqué for further details or contact Ms. Janice Forsythe at the CDA. 

CDA Announces Taxation Seminars

The CDA will hold Taxation Seminars in three (3) major Canadian cities during 1987. Designed to provide current tax information applicable to the dental practitioners' financial activity in both practice and personal environments, the seminars will include such topics as Dental Practice Tax Issues, Professional Management Companies, Professional Corporations, Customs and Excise Impact on the Dental Practice, and Personal Tax Planning.

The CDA's Taxation Seminars will be chaired by Dr. Robert N. Hicks of West Vancouver, B.C. — Chairman of CDA's Taxation Committee, with tax lawyers, tax accountants, customs brokers, etc., featured as lecturers. Current plans will see seminars in Toronto, Halifax and Vancouver during 1987.

The first seminar will take place in Toronto on Friday, March 27, at the Prince Hotel. Confirmed program information and registration forms will be sent to all dentists in Ontario and Quebec towards the end of January.

CDA members outside of these provinces are encouraged to contact the CDA Office (613-523-1770) if they are interested in receiving registration and program information.

The tax seminar in Halifax is planned for late May, while the Vancouver seminar is planned for late September. Detailed information will be sent to CDA members in their respective provinces or in provinces that neighbour, or are close to, these locations at a later date. 

R E L E A S E

OF RADIOGRAPHS TO THIRD PARTIES

Radiographs, along with a clinical examination, provide the basis upon which the dentist makes a complete oral diagnosis. These radiographs form part of the clinical record. However, the Canadian Dental Association has expressed its concern that dental patients should not be exposed to X-radiation for the sole purpose of the verification of eligibility for dental insurance benefits or confirmation of treatment completed.

At the 1986 CDA Board of Governors meeting, the following policy was adopted:

WHEREAS dentists believe that dental patients should not be unnecessarily exposed to radiation;

AND WHEREAS claims supervisors for dental insurers, in many cases, routinely require radiographs to be submitted in support of patient claims;

AND WHEREAS the dentist's professional judgement may not require radiographs for the purpose of patient treatment in such instances;

THEREFORE BE IT RESOLVED THAT the Canadian Dental Association express its concern that dental patients should not be exposed to X-radiation for the sole purpose of verification of eligibility for dental benefits or confirmation of treatment completed; and

THAT this position be communicated to the following:

- (i) the Dental profession across Canada;
- (ii) federal and provincial Ministries of Health;
- (iii) third party carriers of dental services;
- (iv) federal and provincial superintendants of insurance;
- (v) federal and provincial regulatory bodies;
- (vi) The Consumers Association of Canada.

In addition to the above, the Canadian Dental Association has adopted a

policy to identify what type of information should be included in a treatment plan and the timeframe for the submission of this plan to a third party carrier. The following information should be of interest to all dentists.

Regardless of the reimbursement levels enjoyed by the patient from a benefit plan, the decision concerning dental care should be based on information provided by the dentist to the patient. The economic implications of a treatment plan must be considered by the patient, and the decision to proceed with any given plan rests with the patient.

For this reason, the CDA strongly recommends, particularly when prosthetics or extensive treatment is proposed, that dentists assist their patients by providing a completed treatment plan which will be submitted to the carrier. With the treatment plan, the carrier will be able to determine the amount of reimbursement which the patient will receive once treatment has been completed.

In treatment plans where inlays, onlays, crowns and/or bridges are planned, treatment radiographs should be made available at the written request of the carrier's dental consultant. To our knowledge, there are no other circumstances in which dental plan carriers need or should receive dental radiographs.

The advantages of pre-determining patient benefits cannot be over-emphasized. Carriers have responsibilities under the terms of their contracts and must fulfill them. If pre-determination procedures are not followed, carriers will invariably request radiographs when the claim is presented as an aid in determining their responsibilities. It is then too late to obtain a second professional opinion concerning the treatment plan because work has been completed and the circumstances leading to the decision of a treatment plan cannot be duplicated. Even an

assessment of the treatment radiographs at this stage is not particularly useful and the patient may become involved in differences of opinion between the treating dentist and the dental consultant for the carrier.

In cases where pre-determination procedures are not followed, for whatever reason, the carrier, patient and dentist may encounter problems. The carrier may decide not to reimburse the patient until more information is obtained. The patient may or may not have paid the dentist his professional fee, but will no doubt be upset if reimbursement is not forthcoming from the carrier. Regardless of where the blame lies for the lack of pre-determination, the patient will invariably consider the dentist at fault for not complying with the carrier's wishes.

The CDA recommends that, in these circumstances, a member provide an expertise statement to the carrier, describing the information obtained from interpreting the radiographs. However, not all carriers accept these statements. If an impasse occurs, the dentist should contact the Mediations/Arbitration Committee of his Provincial Dental Association.

Carriers can, and have, requested radiographs for procedures other than inlays, onlays, crowns and/or bridges. The reason for these requests is unknown to us, but it is generally accepted that such evidence is not necessary for determination of liability. In our view, this is not a legitimate request if the evidence is required to form an opinion on a treatment plan. Diagnosis and treatment are vital aspects of dental practice and, according to our interpretation of the law, comment on such diagnosis and treatment is considered to be peer review, a right enjoyed only by the Dental Licensing Board of the province.

Despite our views on this matter, many members routinely submit

(Cont'd. on page 8)

(Radiographs cont'd.)

radiographs to carriers upon request, regardless of the propriety or legitimacy of this request. A dentist may wish to assist his patient and avoid any conflict; however, each time a member submits to such a request, it is a stimulus for further requests from that carrier. As we have proven with the development of standard claim forms and other beneficial policies, the only way to achieve our common objectives is for all members to support them and to adhere to our policy guidelines. 

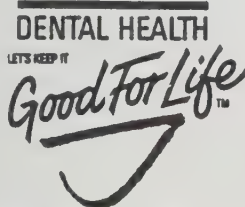
(Adapted from the "CDA Prepaid Dental Plans Policy Manual — Guide to Completing Dental Claim Forms.")

ONTARIO BLUE CROSS CHANGES PROCEDURE

Effective January 1st, 1987 subscribers to Ontario Blue Cross' Extended Health Care and Blue C.H.I.P. plans will not receive claim forms and receipts back from Blue Cross after they have been submitted for payment. This change in procedure will reduce costs and the time required to return claim payments to employees.

A fully-automated claims payment system will computer print on the cheque stub information required for insurance companies when proof of Blue Cross payment is requested. (i.e. employee identification and status; dependant information if the claim is for spouse or children; a detailed explanation of the benefits being paid; and a full explanation if only partial payment is being made.)

Subscribers to the plans are encouraged to take and keep photocopies of receipts which they might need, prior to forwarding them to Blue Cross. 



CANADIAN DENTAL ASSOCIATION

You Owe it to YOURSELF to Support the Canadian Dental Association

The Canadian Dental Association is the national forum for debate, discussion and ultimate resolution of problems facing the profession.

CDA is a composite of its individual parts:

- Provincial Associations and Licensing bodies
- general practitioners
- specialty groups
- educators
- armed forces
- students
- affiliate Societies

Just as the profession owes it to the public to practice preventive dentistry to stave off extensive restorative procedures — so too, do you owe it to yourself to support organized dentistry to protect your interests and your profession.

IT PAYS TO JOIN CDA!

Recent results show that government agencies will listen to our concerns if they are logically and ably presented. Our success in the area of taxation is but one accomplishment. For this reason, it becomes increasingly vital that you — Canada's dentists — support CDA so that we can maintain a strong, unified voice to present your concerns to the Government of Canada.

Keep the
national dental voice strong!
Support CDA by joining today



Canadian Dental Association
1815 Alta Vista Drive, Ottawa, Ontario
Canada K1G 3Y6 Telephone (613) 523-1770

CANADIAN DENTAL ASSOCIATION

DENTAL HEALTH PUBLICATIONS

PAMPHLETS	MEMBER PRICE/100	NON-MEM. PRICE/100	QUANTITY REQUIRED	CODE NO.	TOTAL COST
Are you missing a few teeth?	\$10.00	\$15.00	_____	1	\$ _____
Dental X-Rays Show Hidden Problems ...	11.00	16.50	_____	2	_____
Care Following Minor Oral Surgery ...	12.00	18.00	_____	3	_____
Those Important Baby Teeth	9.00	13.50	_____	6	_____
Prepaid Dental Insurance	20.00	30.00	_____	7	_____
Facts Favour Fluoridation	17.00	25.50	_____	10	_____
Do You Need Complete Dentures?	15.00	22.50	_____	12	_____
Eating Properly for Better Dental Health ..	13.00	19.50	_____	32	_____
Dangerous in Bed (bilingual - (baby bottle syndrome)	9.00	13.50	_____	34	_____
Do You Have Periodontal Disease? ...	12.00	18.00	_____	35	_____
Protect That Mouth! (face and mouth guards)	12.00	18.00	_____	37	_____
Save That Tooth - Get to the Root of the Problem (endodontics)	9.00	13.50	_____	39	_____
Do You Smoke? Have Your Mouth Checked	16.00	24.00	_____	46	_____
Do It Yourself Oral Hygiene	13.00	19.50	_____	47	_____
TMJ Disorder	10.00	15.00	_____	52	_____

CAREER INFORMATION

Choosing a Career ... Dentistry	.40 ea.	.60 ea.	_____	41	_____
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POSTERS

Dental Care is no Laughing Matter (photograph)	1.00 ea.	1.50 ea.	_____	1-E	_____
Teeth - Think About Keeping Them in Their Place	1.00 ea.	1.50 ea.	_____	2-E	_____
Dental Care is No Laughing Matter (illustration)	1.00 ea.	1.50 ea.	_____	3-E	_____
Pamphlet Holder	1 free	7.00 ea.	_____	98	_____
per member					

PLEASE ENCLOSE CHEQUE OR MONEY ORDER
(NO CASH) WITH THIS ORDER FORM

AMOUNT ENCLOSED \$ _____

ADDRESS ALL REQUESTS TO: CDA Order Section, 1815 Alta Vista Drive,
Ottawa, Ontario K1G 3Y6

NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

CDA MEMBERSHIP NUMBER: _____

GOOD FOR LIFE RESOURCES: ORDER NOW!

In this envelope, along with this issue, you'll find your special Order Form. With this form you can stock up on new 1987 Dental Health Month resources — and use them to generate a sense of involvement, momentum, and fun in your own practice. What's more, you can order a selection of practical patient-education and information materials to use year-round.

"EVERY ADULT" A ROARING SUCCESS

Sample copies of "What Every Adult Should Know About Dental Health," DAP's colour-packed foldout publication presenting practical dental health knowledge and advice in a fresh, contemporary style, were sent around to CDA members with their membership renewal forms this year — and the response is overwhelming. "It's amazing," says CDA's information officer Kimberley Allen. "In December alone we've sent out 76,000 copies — and we're getting ready to mail out 68,000 more!"

What's so special about "Every Adult"? The pamphlet's opening remarks state the difference. It's "intended to change the way you think about your dental health . . . and what you do about it." It presents key points on several topics — perspectives on periodontal disease; a new focus on the sulcus; practical suggestions for changing habits; and a look at the partnership between dentist and patient. A favourite section: "It Happened to Harry," a cautionary cartoon fable about . . . periodontal disease.

It's still not too late to order more copies of "Every Adult." Just fill out the enclosed form and mail it back — soon! 

DENTAL HEALTH MONTH 1987

PLEDGE SPECIALS

This year, we have a new theme for Dental Health Month. It's *The Good for Life Pledge* — and its purpose is to get Canadians everywhere to make a personal commitment to their dental health. Dental Health Month materials for 1987 are specially created to encourage people to make the Pledge — to decide consciously and deliberately to do what it takes to keep their dental health **Good for Life**.

As always, we'll be sending you a free in-office kit in March — and this year's relates to the *Good for Life Pledge*. Each member will automatically receive one of each of the following:

• The Pledge Poster

This special poster urges everyone to *Make The Good for Life Pledge*. Printed in vibrant colour, it's perfect for reception-area displays. What's more, patients can actually sign their names on the poster as they make the Pledge.

• The Pledge Button

This year's button is round and colourful. Designed to provoke questions, arouse interest, and add a sense of excitement to Pledge-related events, the button says proudly "I made the Pledge."

• The Motivation Sticker

So popular last year that we'll be shipping it out again. It's a clear, 2" x 2", **Good for Life** logo sticker, with a special motivational message on the peel-off back.

Unfortunately, we can only provide one of each of these free — but you'll probably want more to hand out to your patients. Don't worry. You can order more directly from CDA at a very reasonable price. Just use the enclosed order form. But send your orders in soon while supplies last!

INFORMATION RESOURCES

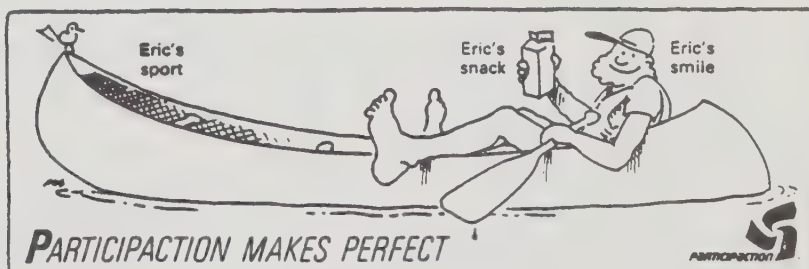
In addition to the 1987 Dental Health Month pledge materials, you can also order these permanent, practical **Good for Life** information resources.

• "What Every Adult Should Know about Dental Health"

This innovative publication is breaking all records as the hottest patient education resource in town. If you haven't already ordered your stock, here's another chance.

• Fact Sheet Pads

These highly-focussed fact sheets are back — this time as practical, 8 1/2" x 11" tear-off pads. Each fact sheet pad contains 100 sheets. These fact sheets are an ideal way to get the right information to the right people. Choose any or all of ten different topics — see your order form for details. 



ONTARIO'S CONSUMER-EDUCATION CAMPAIGN TAKES OFF

If you're practising in Ontario, you're probably already familiar with the Ontario Dental Association's dynamic \$500,000 consumer-oriented awareness and information initiative, which proudly bears the *Good for Life* theme and logo.

But the ODA's program is also of interest to dentists across Canada — for two reasons. The program's flagship booklet "The Consumer's Guide to Dental Care" represents a ground-breaking educational resource likely to be available everywhere. And the program's focus on consumer education will not only provide an essential service to the public — it's also likely to help protect private-practice dentistry from threats such as capitation.

Concern about the cost of dental care is a widespread problem. The ODA's bold and ambitious campaign alerts the public to the issues — and then comes through with sound information about how best to deal with them. Watch for campaign details in upcoming Dental Awareness Program Updates. 

REMEMBER



CANADIAN DENTAL ASSOCIATION CONVENTION

in conjunction with
les journées dentaires 1987

May 24 - 28



CANADIAN DENTAL ASSOCIATION

CDA Library/Resource Centre

THE SYDNEY WOOD BRADLEY MEMORIAL LIBRARY OF THE CANADIAN DENTAL ASSOCIATION

As a free service to all members, both dentists and students, and affiliated dental groups the CDA Library/Resource Centre is presently offering the following:

- MEDLINE literature searches: this computerized information retrieval system provides access to over 3,000 medical and dental journals and produces instant bibliographies of varying length and depth of topic coverage. The Association is accepting collect calls for this service from all members. There is a \$25.00 fee for non-members for each search.
- SDI: this is a monthly current awareness bibliography. The requester's original search in MEDLINE is stored in the computer and updates are then sent automatically twelve times a year. There is a monthly charge of \$25.00 for non-members.
- Copies of contents pages of the most current dental journals. There is a monthly charge of \$5.00 to non-members for this service.
- Photocopies of journal articles. All reasonable requests will be processed free of charge to CDA members; there is a \$5.00 administrative fee for non-members.
- "Package Libraries": these are selected articles on topics of interest to the dental community and advertised each month in the Journal. One copy of each article listed is provided free of charge to members and a \$5.00 fee for non-members.
- General inquiries on dentally related topics: assistance is provided free of charge to all members; there may be a \$5.00 fee for non-members depending on the extensiveness of the request.

The Library is open from Monday to Friday between 8:30 a.m. and 4:30 p.m.

For further information please contact Trudi Di Trollo, Librarian at the Canadian Dental Association, 1815 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6, (613) 523-1770, extension 223.

CANADIAN DENTAL ASSOCIATION

August 24 – 27 août 1986

Halifax, Nova Scotia

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_____	August 25 août		_____	August 26 août	
_____ CDA 1	Opening Breakfast – Keynote Address	Mr. Don Green	_____ CDA 10B	Horizons in Dentistry	
_____ CDA 2A	Grieve Memorial Lecture –	Dr. Frank Shamy	_____ CDA 10C		
_____ CDA 2B	Orthodontics		_____ CDA 10D		
_____ CDA 3A	Orthodontics and Periodontics: The Foundational Basis	Drs. Normand Boucher and Harvey Levitt	_____ CDA 11A	Oral and Maxillofacial	Dr. David Precious
_____ CDA 3B	for Restoration of the Compromised Adult		_____ CDA 11B	Surgery	
_____ CDA 3C	Dentition		_____ CDA 12A	Practice Development	Mr. Wilson Southam
_____ CDA 3D	Endodontics	Dr. Phillip Molloy	_____ CDA 12B		
_____ CDA 4A	Oral Pathology – Birth	Dr. Michael Cohen	_____ CDA 12C		
_____ CDA 4B	Defects and Dentistry		_____ CDA 12D		
_____ CDA 5A	Research in Future Trends –	Dr. Harold Slavkin	_____ CDA 13A	Health Screening Program	Dr. Patrick Blahut
_____ CDA 5B	Research Opportunities for the 21st Century		_____ CDA 13B	An Update	
_____ CDA 6A	Dental Awareness: How It Can Work For You	Mr. Mark Sarner	_____ CDA 14A	Dental Biomaterials – The	Dr. Derek Jones
_____ CDA 7A	The Role of Antimicrobials in the Treatment of Periodontal Disease	Dr. Trevor Chin Quee	_____ CDA 14B	Future of Biomaterials	
_____ CDA 7B			_____ CDA 15A	Maxillofacial Prosthetics:	Drs. Robert Hoar
_____ CDA 8A			_____ CDA 15B	From Womb to Tomb Head and Neck Cancer: A Trilogy of Care	Robert Brygider
_____ CDA 8B					
_____	August 26 août		_____	August 27 août	
_____ CDA 9A	Periodontics – Surgical	Dr. Jay Seibert	_____ CDA 16A	Successful Removable Partial	Dr. Robert Chapman
_____ CDA 9B	Reconstruction of Deformed		_____ CDA 16B	Dentures	
_____ CDA 9C	Pontic Areas		_____ CDA 17A	Dentistry and the Law –	Mr. Lorne Rozovsky
_____ CDA 10A	Restorative Dentistry – New	Dr. David Garber	_____ CDA 17B	Future Trends	
			_____ CDA 18A	AIDS Related Disease and	Dr. John Hardie
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			_____ CDA 19B	A Symposium Update	

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MEMORANDUM

October 6, 1986

TO: Executive Council

FROM: Dr. Robert N. Hicks
Chairman - Taxation Committee

SUBJECT: Taxation Committee
Future Activities

CDA Taxation Committee was established in 1978. Since that time, it has been involved in presentations to the federal government on the following issues:

1) **Continuing Education Expenses**

Objective: - To have these costs accepted as a tax deductible expense against professional income

Result: - Acceptance by Revenue Canada

2) **Duty on Imported Dental Materials**

Objective: - To have the duty imposed by the Department of Finance removed

Result: - Duties were removed on most dental materials but the duty on amalgam and similar dental filling materials were retained by the Department of Finance

.../2

3) Retirement Income Provision for Self-Employed Professionals

Objective: - To increase the allowable contributions provided under the RRSP legislation and to broaden the regulations to provide equity to the self-employed professional vis-a-vis the employed sector at an executive level

Result: - Department of Finance accepted the principle of equity in this area

4) Taxable Status of Employer Contributions to Employee Dental Plan

Objective: - To retain the tax exempt status of employer contributions

Result: - Department of Finance retained the tax exempt status of employer contributions

5) Revenue Canada Audits on Professional Management Companies

Objective: - To achieve acceptance by Revenue Canada of a "reasonable" profit for Professional Management Companies and to strongly oppose the retroactive nature of the 1981 Revenue Canada directive to impose a "restricted" profit allowance on PMC's

Result: - Acceptance by Revenue Canada of a "reasonable" profit for PMC's and a reversal of the retroactive application of their 1981 directive

6) Federal Sales Tax Application to Dental Impression Materials

Objective: - To have this federal sales tax application removed

Result: - Revenue Canada removed the federal sales tax on dental impression materials

7) Federal Sales Tax Application on All Dental Materials and Orthodontic Articles and Appliances

- Objective: - To have the federal sales tax removed from dental materials and orthodontic supplies and appliances
- Result: - Revenue Canada removed federal sales tax from these items

During the course of events leading to the positive decision for some of these objectives, the CDA Taxation Committee was responsible for forming the Joint Professional Committee with representatives from the Canadian Institute of Chartered Accountants, the Canadian Medical Association, the Canadian Bar Association and the Canadian Dental Association. The CDA was responsible for the administrative structure and functions of this Committee, and its representative acted as the Chairman of this group.

It is of interest to speculate on the financial implication of these activities that impact on the self-employed dental profession in Canada. Impact on the self-employed dentists (CDA members and non-members) must be based on assumptions only since facts related to true financial impact are time consuming to obtain. The following is a "best guess" and should not be quoted with authority:

Annual Benefit

1. Continuing Education Expenses

Assumption:	- 10,000 dentists	
	- \$2,000 annual cost	
	- 50 % tax rate	\$10,000,000

2) Duty on Imported Dental Materials

Assumption:	- 10,000 dentists	
	- \$8,000 annual cost	
	- 14 % duty	\$11,000,000

3) Retirement Income Provision

Assumption:	- 10,000 dentists	
	- \$2,000 increase 1986	
	- 50 % tax rate	\$10,000,000

4) Professional Management Companies

Assumption:	- 6,000 dentists	
	- \$10,000 increase 1986	
	- 1/2 x 50 % tax rate	\$15,500,000

5) Dental Impression Materials

Assumption:	- 10,000 dentists	
	- \$2,000 cost	
	- 11 % tax rate	\$2,000,000

6) Federal Sales Tax - Dental Materials/Orthodontic Supplies and Appliances

Assumption:	- 8,000 dentists	
	- \$15,000 cost	
	- 11 % tax rate	\$1,300,000
	- 500 ortho	
	- \$30,000 cost	
	- 11 % tax rate	\$1,600,000
	- 3,000 G.P./ortho	
	- \$8,000 cost	
	- 11 % tax rate	\$2,600,000
	TOTAL	\$54,000,000

It should be noted that the annual benefit to dental practitioners of the tax exempt status of employer contributions to private dental insurance plans is not listed. This benefit is impossible to calculate but certainly would equal if not surpass the total of the above list. This list does not include benefits received by other self-employed professionals in Canada.

This brief review makes the point that the CDA has been providing considerable financial benefit to our profession. However, the impact on the individual dentist is only \$5,400 annual tax savings, which hardly "makes or breaks" his year. To further the impact on the individual dentist and thereby improve the CDA image regarding taxation matters, the following recommendation is put forward for the consideration of the Executive Council:

Recommendation:

THAT the Taxation Committee enter into the area of providing information on taxation matters, which affect the individual dentist. This information would deal with specific practice management matters that would maximise tax benefits as they exist under the law in a management of a dental practice, and also as tax law affects the personal tax return of the dentist.

The information provided would be based on existing practices of Revenue Canada and would not be aimed at providing methods of "clever avoidance" of tax or new "innovative" interpretations to outwit Revenue Canada.

The format for providing this information would be twofold:

- i) Quaterly "CDA Tax News" Bulletins on relevant tax matters. This bulletin would be separate from the CDA Communiqué or special release bulletins and would be sent on special "CDA Tax News" letterhead. Preparation of material would be provided by the Taxation Committee or by "guest articles" from tax accountants and tax lawyers.
- ii) CDA Tax Seminars in major provincial cities on a rotating basis (three to four seminars each year). Tax accountants and tax lawyers from local area or province would be the main speakers with CDA chairing these seminars and providing the administrative services. Tuition would be charged and the seminars would operate on a "no cost to CDA" basis.

Comments have been received indicating that CDA is not receiving due credit from the membership for the work it is doing in the taxation field. These two communications vehicles can provide valuable information to our colleagues, while CDA gains high profile and full credit. To enhance membership, a lower tuition cost could be given to CDA members at the seminars, and the CDA Tax News Bulletin could be mailed to members only.

If Executive Council approves these two new projects in principle, the Taxation Committee will provide financial information related to each.

/ml

MEMORANDUM

December 9, 1986

TO: Mr. A. Jardine Neilson
Executive Director

FROM: Dr. Robert N. Hicks, Chairman
Taxation Committee

SUBJECT: CDA TAXATION SEMINARS

At the request of the Executive Council, the following is additional information supporting the Taxation Committee's proposal to initiate CDA Taxation Seminars.

LOCATIONS: The Seminars will be held in major provincial cities at hotels which are convenient to attract participants within the province, but also attractive to those participants travelling from neighboring provinces. Consideration will be given to those using air transportation.

The Seminars will be located in a western province, a central province and in an atlantic province during the course of the year to provide maximum access. The individual provincial location will be alternated (or rotated) each year during the initial stages due to the limited number of seminars each year. For example, in the first year, the provinces of Ontario, Nova Scotia and British Columbia are being considered.

FREQUENCY: It is anticipated that a maximum of three (3) seminars each year would be organized.

.../2

PURPOSE:

The seminars will provide current tax information that will be applicable to the dentist's financial activity in both his practice and personal environments. The major thrust of the seminars will be aimed at the application of the existing tax laws, but will not focus on tax sheltering schemes, tax avoidance, or on other esoteric tax planning procedures. The Income Tax Act, the Excise Tax Act, the Customs Act and Regulations and Schedules to these Acts will form the basis of the lecture agenda.

A typical agenda for the seminars would include the following subjects:

1. Professional Management Companies

- Update on current tax policy
- Their viability as a tax planning vehicle
- The Personal Services Business Definition
- The tax treatment on retained earnings

2. Professional Corporations

- Their structure and legal requirements
- Tax advantages to incorporation
- Income splitting and estate planning
- Tax treatment on assets in the corporation
- How to remove assets from the corporation

3. Customs and Excise Impact on the Dental Practice

- Current customs regulations
- Current federal sales tax regulations
- Requirements for refunds under the Excise Tax Act

4. Retirement Financial Planning

- The use of RRSPs and RIFs
- The retirement planning process

5. Personal tax planning

- The alternative minimum tax
- At risk rules
- Family Tax Act (Ontario)
- Interest expense
- Mortgage payments as a deductible expense
- Income splitting within your family
- Automobile expense

Etc.

LECTURERS: Tax accountants, tax lawyers, customs brokers, etc., will be used as lecturers. These individuals would be selected from the area where the tax seminar was being presented, and would provide their services without cost to the CDA.

The Chairman of the CDA Taxation Committee will act as Chairman of the seminars and would be assisted in the promotion, organization, registration, etc., of the seminars by the CDA Coordinator assigned to the Taxation Committee's activities.

COSTS: A registration fee will be charged for participants in seminar. A registration fee of \$85.00 for CDA members, and \$150.00 for non-members is recommended. This fee would include lunch and any hand-out material that may be appropriate. Promotion will be directed towards dentists in the province where the seminar is taking place and in neighboring provinces where applicable. Local tax lawyers and tax accountants may also wish to attend these seminars. Advertisement in the CDA Journal will provide information on the seminars to the general dental population in Canada.

A suggested budget for the 1987 seminar activity on an individual average seminar basis is attached to this memorandum.

SCHEDULE: A tentative schedule for 1987 seminars is as follows:

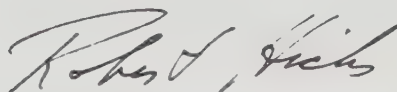
March - Toronto, Ontario

June - Halifax, Nova Scotia

September/October - Vancouver, B.C.

In summary, the Taxation Committee is requesting final authority to proceed with the first three (3) seminars. Review of the experience would occur after each seminar, and approval to proceed in 1988 would be requested in the Fall 1987.

Respectfully submitted.



Robert N. Hicks, D.D.S., M.S.
Chairman - Taxation Committee

**1987 Budget
CDA TAXATION SEMINARS**

Average Budget (based on 125 delegates)

INCOME:		<u>Individual \$ Amounts</u>	<u>Total Amounts</u>
Registration Fees	- \$100 members x 125 - \$150 non-members		\$12,500.00
EXPENSES:			
Speakers - Honorarium		Nil	
Meeting Room		\$500.00	
Equipment		\$100.00	
Lunch (\$20 x 125)		\$2,500.00	
Promotion/Registration Forms (1)		\$1,500.00	
Seminars hand-out materials		\$500.00	
Meals and Accommodation (2 days)			
- Chairman		\$350.00	
- Coordinator		\$350.00	
Travel (2)			
- Chairman		\$900.00	
- Coordinator		\$600.00	
Chairman's Per Diem (2.5 days) (3)		\$810.00	
			<u>\$8,110.00</u>
EXCESS INCOME OVER EXPENSES (4)			\$4,390.00

- (1) Efforts will be made to reduce this cost through utilization of regular CDA mailings, etc.
- (2) Calculation of average travel expense is as follows:
- | | | |
|---------------------------|-----------------|-------------------|
| Chairman - from Vancouver | Atlantic Prov. | \$1,400.00 |
| | Central Prov. | \$1,000.00 |
| | Western Prov. | \$300.00 |
| | Total: | <u>\$2,700.00</u> |
| | Average: | \$900.00 |
-
- | | | |
|----------------------------|-----------------|-------------------|
| Coordinator - from Ottawa: | Atlantic Prov. | \$400.00 |
| | Central Prov. | \$200.00 |
| | Western Prov. | \$1,100.00 |
| | Total: | <u>\$1,700.00</u> |
| | Average: | \$600.00 |
- (3) Chairman's Per Diems includes one day travel, one day seminar, one day travel for atlantic and central provinces but would only be one day seminar plus one half-day travel to western provinces. An average of 2.5 days has been used.
- (4) Break-even registration for each seminar would be 81 people at \$100 each (\$8,100).

BUDGET
1987 TAXATION SEMINAR - TORONTO

Budget (based on 150 delegates)

INCOME:		Individual \$ Amounts	Total Amounts
Registration Fees	- \$100 members x 150		\$15,000.00
EXPENSES:			
Speakers - Honorarium		Nil	
Meeting Room		\$500.00	
Equipment		\$100.00	
Lunch (\$20 x 150)		\$3,000.00	
Promotion/Registration Forms		\$1,500.00	
Seminars hand-out materials		\$500.00	
Meals and Accommodation (2 days)			
- Chairman		\$350.00	
- Coordinator		\$350.00	
Travel			
- Chairman		\$1,000.00	
- Coordinator		\$200.00	
Chairman's Per Diem (3 days)		\$782.00	
			<u>\$8,285.00</u>
EXCESS INCOME OVER EXPENSES			\$6,715.00

THIRD PARTY DENTAL PLANS COMMITTEE

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. D.E. MacFarlane, Chairman, Vancouver
 Dr. T. Gushue, St. John's
 Dr. D. Gutkin, Winnipeg
 Dr. W. Leggett, Brampton

 Dr. D.E. MacFarlane, Executive Liaison, Vancouver

1. Committee Meetings

The Committee has met three times since the 1986 Annual Board of Governors Meeting. The meeting dates were August 24, 1986, November 16-17, 1986 and January 11-12, 1987.

Liaison activities - the committee met with:

Representatives of the Canadian Life & Health Insurance Association Inc. on January 12, 1987.

Representatives of Blue Cross on March 4 1984.

Items Requiring Board Action

2. Revision to CDA Uniform System of Codes & List of Services

In an effort to encourage dentists to assist in controlling the rising cost of dental care, the acceptance of the following codes is recommended.

RESOLVED:

87.44	11200	PREVENTIVE PACKAGE RECALL Including: recall examination, prophylaxis and topical fluoride (excluding radiographs)
	11211	Primary dentition
	11222	Mixed dentition
	11233	Permanent dentition

ADOPTED

THIRD PARTY DENTAL PLANS COMMITTEE

- 2 -

NOTE: The Committee is continuing its major revision of the entire list and plans to present the final document to the Annual Board of Governors meeting in September.

3. Release of Patient Records

The Committee was concerned that some capitation plans include requirements that participating dental practices must make patient records available for audit by representatives of the contract holder. These audits are reportedly conducted to permit comparison levels of care provided under capitation funding and under fee-for-service or other funding arrangements. Such audits may contravene provincial dental legislation and/or codes of ethics, in that written permission to release the dental records of non-capitation patients may not have been obtained.

RESOLVED:

87.45 THAT the provincial licensing authorities be requested to:

- (a) remind dentists that the release of patient records to a third party agency requires the written consent of the patient; and
- (b) emphasize the principle that, with written consent, patient records should only be released to a third party agency when required in the patient's direct interest.

ADOPTED

4. CDA Policies on Prepaid Dental Plans

APPENDIX I

The Committee has undertaken a major revision of the CDA Prepaid Dental Plans Policy Manual. (See Appendix I). The revised manual has been sent to the corporate bodies with a letter notifying them that the Committee will be presenting the manual to the 1987 Interim Board of Governors meeting for approval.

THIRD PARTY DENTAL PLANS COMMITTEE

RESOLVED:

- 87.46 THAT the CDA Prepaid Dental Plans Policy Manual - Guide to Completing Dental Claim Forms be approved as amended.

ADOPTED

NOTE: Ontario Governors abstained.

Please note that we are requesting approval from the appropriate national bodies for a change in format only to the standard orthodontic and periodontic endorsement forms. The revised forms will be inserted into the manual as soon as possible.

5. Notice to Patients

The Committee reviewed and adopted a Notice to Patients developed by the Halton Peel Dental Association (See Appendix II). The notice is designed to be routinely handed out with dental treatment forms.

APPENDIX II

RESOLVED:

- 87.47 THAT the appended Notice to Patients be approved.

ADOPTED

Items for Information - Not Requiring Board Action

6. Capitation

In October the Committee published its first issue of TIPS - A Handbook on Capitation. Positive feedback has been received on the information contained therein.

The next issue of TIPS will be on Direct Reimbursement.

THIRD PARTY DENTAL PLANS COMMITTEE

7. National Strategy re: Public Information Campaign

The Committee has been actively soliciting funds from across the country to support the development of a Public Information Campaign on dental practice in general and alternative delivery systems. The campaign will be adapted from the Ontario Dental Association campaign.

As of January 28, 1987, the College of Dental Surgeons of British Columbia had pledged \$175,000 to help fund this project. Many other corporate bodies have approved support in principle and it appears that funds will be forthcoming. It has been indicated that the provincial associations hope to be able to support the campaign as follows:

Alberta	-	a minimum of \$25,000
Saskatchewan	-	\$100 per dentist
Manitoba	-	contributions will be voluntary \$30,000 is expected
Quebec	-	T.B.A.
New Brunswick	-	\$15,000
P.E.I.	-	\$5,000
Nova Scotia	-	\$100 per dentist
Newfoundland	-	contributions will be voluntary \$5,000 is expected.

The Committee would like to be able to duplicate the Ontario campaign, but that will depend on the funds raised. If the money is not forthcoming, some elements may have to be cut. The following, however, are the desired elements of the campaign:

1. posters and pamphlets to be distributed through dental offices;
2. a form letter to be sent to patients;
3. magazine ads to promote dental awareness;
4. radio advertisements to promote dental awareness (these will be used in conjunction with the magazine ads if there is a shortage of money).

In addition, the Committee feels the following are of the utmost importance in the preservation of fee-for-service dentistry:

1. the development of a Purchaser Contact Program;
2. marketing aspects and fee guide changes;

THIRD PARTY DENTAL PLANS COMMITTEE

3. an increase in demand for dental services;
4. reduction in the number of dentists graduating from dental schools;
5. student contact programs;
6. government relations; and
7. public information programs.

Several other CDA committees are also working towards achieving the above goals. Dramatic results cannot be expected over the short term, but progress is being assisted by the CDA's dental awareness program and can be quickened by additional targetted media campaigns — if necessary funding can be found. The Committee urges all Canadian dentists to support pursuit of the above goals and to contribute funds to help mount the Public Information Campaign on Dental Practice and Alternate Delivery Systems.

8. Canadian Life and Health Insurance Association

The Committee met with representatives of CLHIA on January 12, 1987 and discussed the many issues surrounding capitation. It would appear that several of the major carriers are still considering implementing Capitation plans, but no details of proposed plans were offered. The Committee will continue to monitor the situation.

The joint meeting also addressed the Newfoundland Dental Association position that all dental consultants reviewing claims in Newfoundland must be licensed in that province. The Committee reiterated its support of such a position.

9. Federal Public Service Dental Plan

The Committee has reviewed the outline of the proposed Public Service Alliance dental plan. Although this is a good, basic plan, the Committee did have some suggestions which have been forwarded to the Public Service Alliance, the Treasury Board and the International Brotherhood of Electrical Workers.

Part of the plan was instituted on March 1, 1987 and additional groups will be phased in over time.

THIRD PARTY DENTAL PLANS COMMITTEE

10. Dental Care Programs in Canada

The Committee is undertaking, with the assistance of the corporate bodies, a critique of Dental Care Programs in Canada, a report published by National Health and Welfare. The Committee has expressed concern that organized dentistry was not invited to participate in the development of the report. It is felt that some of the information contained in the report does not reflect the current situation as no practising dentists had input. The Committee feels CDA should go on record with Health and Welfare Canada and the authors of the report with a formal critique.

11. Exposure of Patients to Radiation

At the 1986 Annual Board of Governors meeting, CDA adopted a position on the exposure of patients to radiation solely for the purpose of supporting insurance claims.

APPENDIX III

The Third Party Dental Plans Committee also notes that, due to changing disease patterns in Canada, new direction has been taken regarding the amount of radiation and the number of radiographs which are deemed to be appropriate on a regular basis. The Committee would like to see the new recommendations become widely accepted. These recommendations can be found in the attached article entitled "Prescription Radiography" (See Appendix III). This article is by R.G. Stephens et al and was published in the CDA Journal (No. 9, 1985).

12. Standard Dental Claim Form

The CDA Standard Dental Claim Form has now been produced and went into effect January 1, 1987. It appears to be well received by both carriers and dentists.

13. Committee Structure

In order to accommodate the growing desire for input into the Committee and yet maintain its current size, a new structure has been adopted. In addition to the current members of the Committee and its Sub-Committee on Alternative Delivery, material will now be sent to corresponding members in each of the provinces, upon request from the provincial association. These corresponding members will have the opportunity to comment on Committee initiatives before each meeting.

THIRD PARTY DENTAL PLANS COMMITTEE

14. The Committee would like to thank all those across Canada who have assisted in our many projects.

Respectfully submitted,

D.E. MacFarlane, D.M.D.
Chairman,
Third Party Dental Plans Cttee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Third Party Dental Plans Committee with appreciation.

The Board of Governors expresses its gratitude to the Third Party Dental Plans Cttee regarding its achievement re: the CDA Prepaid Dental Plans Policy Manual and the Capitation issue.

CDA PREPAID DENTAL PLANS

POLICY MANUAL

**GUIDE TO COMPLETING
DENTAL CLAIM FORMS**

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Provincial Guidelines and Policies may differ and should prevail over and above those contained in this Manual.

April 1987

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PREAMBLE

**CANADIAN DENTAL ASSOCIATION DENTAL PLANS POLICY MANUAL
GUIDE TO COMPLETING DENTAL CLAIM FORMS**

The following pages contain important information for all dental practices in Canada.

These CDA Policies and Guidelines have been developed in the best interests of the dentist and the patients in his care. The Third Party Dental Plans Committee has determined that the majority of problems arising between third party carriers, patients and dentists occur because some or all of the CDA Guidelines are not followed.

Each practitioner should be fully aware of this publication and its contents and EACH OFFICE STAFF PERSON SHOULD BE COMPLETELY FAMILIAR WITH ITS SUGGESTIONS. THESE GUIDELINES PROVIDE PERTINENT INFORMATION WHICH, IF USED PROPERLY, WILL PREVENT MANY PROBLEMS. A COPY OF THESE GUIDELINES SHOULD BE RETAINED AND REFERRED TO ON AN ONGOING BASIS IN DEALINGS WITH THIRD PARTIES.

If the Guidelines are followed fully, few difficulties will occur regarding problems between patients and third party carriers.

THE DENTIST AND THE PREPAID PLAN

The ongoing evolution of prepaid dental plans has prompted many dentists to pay more attention to them. It is not the suggestion, nor should it be implied that CDA supports a more aggressive relationship between ourselves and the carriers. However, even when we are aware that a patient presenting for dental treatment has some form of third party coverage, we must conduct our practices in an honest and ethical manner. That is not to say that we must "knuckle under" to unreasonable requests from carriers, nor should we allow our practices to be dictated to by others.

What we must do is conduct our practices as we would in the absence of a third party. The patient's treatment must be geared to those procedures necessary to provide optimum dental health for our patients. Treatment plans must never be tailored to the coverage in a patient's contract. To tailor our treatment to benefit plans puts our profession in a very poor light and renders us no more than technicians - a situation which will create more and more interference between the profession and prepaid plan carriers.

Certain Guidelines within these pages function to allow a smooth transfer of information between practitioner and carrier.

The treatment form has been changed significantly. Changes have been instituted to allow a better method of describing treatment objectives to the patient and, where necessary, to the carrier. The form has been, and still is, primarily for the patient's benefit, to contain information which the patient can understand. However, it is recognized that the form is also a vehicle to be used by the patient to find out what benefits he is eligible for under the terms of his specific dental prepayment plan. To this end we would again strongly urge all members to provide a detailed written description of the proposed procedure when estimating "other services".

Remember, neither a patient nor a carrier can be fully aware of what is meant by the term "crown" or "bridge" or "partial denture" only. A treatment form bearing this limited description of the services suggested will not enable a detailed estimate of coverage for our patients' knowledge. Wording such as "porcelain bonded to metal crown" on the indicated tooth, or "lower cast free end partial denture" provide better detail. By accurately describing the proposed treatment, you may avoid unnecessary and perhaps critical delays in the time required to obtain the pre-determination response for your patient.

It is also suggested that an estimate of the laboratory charges be included on the treatment form.

A written complete cost breakdown should be provided to all patients whenever possible. While an exact dollar value is impossible, the prudent dentist should make the patient more aware of what "plus L" really is in dollars. Confusion certainly will be less of a problem.

For pre-determination of benefits, the treatment form should be used. Although we would encourage you to use the treatment form, the Standard Dental Claim Form may be used if "for pre-determination only" is clearly marked IN THE DENTIST'S COMMENTS SECTION.* This will allow those dentists who use a computer in their offices to only set up for one form.

- * The Ontario Dental Association does not recommend this practice for its members.

FEES

Your current provincial Fee Guide for General Practitioners is an integral part of all dental offices, along with the CDA Prepaid Dental Plans Policy Manual.

The fee guide is readily available to all carriers. They use it routinely in all cases of claims for dental services. The CDA wants to make all practitioners who use the fee guide fully aware that its use is only as a guide. The concept that this is a fee schedule must be totally removed. We would draw all practitioners' attention to the preamble of the fee guide and suggest a complete review of its contents by all members.

Some additional points should be noted:

There can be a tendency among us to equate the fee charged for services to that printed in the fee guide. The CDA reminds you that the calculation of fees for individual services must come about only after careful study of the guide. Fees charged must be "realistic", taking into account the responsibility, time and difficulty, as well as the economic climate of the area in which you work. Each practitioner must also take into consideration office overhead in this calculation. An hourly dollar figure can be determined only after all of these factors are considered. Once this value is known it becomes possible to relate the fee guide to this figure. After a fair assessment, it will become apparent that fees can be realistically charged which are within the fee guide and that a tendency to routinely charge the maximum is not necessary.

Remember, responsible, realistic fees will allow appropriate reimbursement for services rendered. Patients and carriers are very aware of fees charged and, particularly, the patient must be made aware of these fees prior to commencement of treatment.

A thorough discussion of fees to be charged all patients (including those who have third party coverage) is strongly suggested prior to treatment.

GLOSSARY OF TERMS

ALTERNATE BENEFIT CLAUSE (ABC)

Definition:

An indemnity contract provision which authorizes the third party to determine the amount of benefits payable, giving consideration to professionally accepted alternate procedures, services or courses of treatment that may be performed to accomplish the desired result. The attending dentist and the patient may proceed with the original treatment plan, regardless of the third party benefit determination.

Comment:

The Canadian Dental Association is opposed to the concept of the Alternate Benefit Clause. However, they are present in virtually all contracts between purchasers and third parties. Members should adhere to the suggestion that it is wise to await the carrier's pre-determination of benefits prior to starting major crown and bridge or denture procedures. Neither CDA nor the provincial associations can eliminate these clauses in the contracts.

ARBITRATION COMMITTEE

See Mediations Committee of a Provincial Dental Association.

ASSIGNMENT OF BENEFITS

Definition:

An indemnity contract procedure whereby the subscriber/patient authorizes the third party to make payment of any allowable benefits directly to the dentist.

Comment:

The CDA does not recommend assignment of benefits. (See page 20 - Payment Assignment.)

AUDIT

Definition:

The qualitative or quantitative review of dental services rendered or proposed by a dentist, which may take the form of a comparison of patient records and claim form information, a patient questionnaire, an examination of pre- or post-operative radiographs, or a pre- or post-treatment clinical examination of a patient. An audit may also involve fee verification.

Comment:

CDA believes that any inquiry that goes beyond the routine confirmation of patient-related data is deemed to be an audit and within the sole discretion of the provincial licensing body.

BENEFIT

Definition:

The amount payable by the third party under an indemnity contract toward the cost of various covered dental services.

CAPITATION

Definition:

A method of payment in which the contracting dentist, rather than a third party intermediary, assumes the financial risk of assuring that contracted dental services will be available to the patient. In return for a fixed per capita payment the dentist agrees to provide a specified set of services, on demand and as needed, to a subscriber group, for a specific period of time.

Payment to the dentist is based upon the number of persons eligible for dental treatment during a payment period, whether or not the enrollees avail themselves of the dental services during that period.

Comment:

The CDA is concerned that capitation schemes may not provide a sound basis for full and comprehensive dental care and may introduce other restrictions on the delivery of patient care. (See CDA "Handbook on Capitation".)

CAPITATION PAYMENT METHODS

Definition:

- | | |
|-----------|---|
| Fee | a fixed periodic payment, paid to the provider of care by the third party, based on the number of eligible patients assigned to the provider for treatment. |
| Surcharge | specified additional contractual co-payment for specific services, payable by the patient directly to the dentist. This concept is present in almost every capitation plan. |
| Premium | a fixed periodic payment paid to an administrative organization to provide dental care to the covered individual or group. |

CARRIER

See Third Party.

CERTIFICATE HOLDER

Definition:

The person, usually the employee, who represents the family unit covered by the pre-payment program.

CLAIM FORM

Definition:

The form used to file for benefits under an indemnity-type pre-payment plan and which includes a section for the patient and the dentist (attending dentist statement).

CLOSED PANEL

Definition:

A closed panel practice is established if patients eligible for dental services in a private or public program can receive these services only at specified facilities by a limited number of dentists.

Comment:

CDA believes that the closed panel approach deprives the patient of freedom of choice of his treating dentist and deprives the dentist of his freedom of choice of patients.

CO-INSURANCE/CO-PAYMENT

Definition:

That percentage of the dentist's fee not reimbursed to the patient according to a sharing formula specified in the indemnity contract between the subscriber/insured and the third party. In all cases the patient is responsible for payment of the total fee charged by the dentist.

Comment:

CDA believes that co-insurance promotes the patient's realization of responsibility for his or her own oral health.

COMPLAINTS COMMITTEE OF A PROVINCIAL DENTAL LICENSING BOARD

Definition:

A committee under provincial dental legislation which receives complaints from the public concerning possible misunderstandings and grievances or infractions of legislation and which is authorized to mediate, if proper and possible, or to refer the case for other action.

CONTRACT PRACTICE

Definition:

A contract practice is established when an employer or administrator contracts directly with a dentist or a group of dentists to provide dental services for eligible members, usually in a closed panel concept.

CO-ORDINATION OF BENEFITS

See Dual Coverage.

COSMETIC DENTISTRY

Definition:

Those services provided by dentists, primarily for the purpose of improving the appearance of the patient, when form and function are satisfactory and no pathologic conditions exist.

COVERED SERVICES

Definition:

Those services specified as included under a prepaid plan contract.

DEDUCTIBLE

Definition:

A stipulated sum the covered person must pay toward the cost of dental treatment before the benefits of the indemnity-type program go into effect. The deductible may be annual or payable only once and may vary in amount from program to program.

DENTAL INSURANCE PLAN

See Prepaid Dental Program.

DENTAL PREPAYMENT ADVISORY, THIRD PARTY OR INSURANCE COMMITTEE OF A PROVINCIAL DENTAL ASSOCIATION

Definition:

A properly constituted committee of a Provincial Dental Association whose mandate it is to:

- review the existing policies of the Provincial Dental Association regarding prepaid dental plans;
- suggest and draft proposed changes which from time to time become necessary in these policies;
- advise and inform the profession on matters relating to prepaid dental plans;

- convey the guidelines and policies of the Provincial Dental Association to prepaid dental plan carriers and administrators;
- design and/or recommend revisions to various standard dental prepaid plan forms, together with instruction sheets, in consultation with the Canadian Dental Association and prepaid plan carriers;
advise the public, public groups, and the prepaid dental benefit carriers on matters of dental health "insurance";
- advise the Association regarding failure by any prepaid plan, carrier, administrative agency, or dentist to comply with the recommended policies and guidelines of the CDA/Provincial Dental Association;
- assist the public, dentist or prepaid plan agencies in resolution of matters of concern/problems/disagreement between the parties.

DENTAL SERVICE CORPORATION

Definition:

A legally constituted, not-for-profit organization sponsored by a provincial dental society to negotiate (underwrite) and administer contracts on an indemnity basis for provision of dental services.

DENTAL SERVICE PLAN

Definition:

A dental prepaid plan that ensures the provision of specified dental services to subscribers as opposed to indemnifying dental expenses.

DIRECT CONTRACT

See Health Maintenance Organization (HMO).

DIRECT REIMBURSEMENT MECHANISM

Definition:

A method of assistance in which beneficiaries are reimbursed by the employer or benefits administrator for any dental expenses, or a specified percentage thereof, upon presentation of a paid receipt or other evidence that such expenses were incurred. This method does not require the services of an insurance company but the financial risk is assumed by the employer.

DISCIPLINES COMMITTEE OF A PROVINCIAL DENTAL LICENSING BOARD

Definition:

A statutory committee under provincial dental legislation which receives information from a sub-committee or other sources concerning possible infractions of provincial dental legislation or its associated by-laws and has the power to make legal and punitive decisions.

DUAL CHOICE

Definition:

Any individual or family group enrolled in a plan is offered the choice of coverage through a closed panel capitation program or an indemnity-type fee-for-service program.

Comment:

The benefits under dual choice may or may not be identical under the terms offered in the two options.

The persons exercising "dual choice" must commit themselves upon entrance to the plan, and may only switch from one to the other at specific dates stated in the contract.

DUAL COVERAGE

Definition:

A method of integrating benefits payable under more than one group dental prepaid plan so that the insured's benefits from all sources do not exceed 100% of his allowable dental expenses.

EXPERTISE LETTER

Definition:

A professional letter which requires the dentist's professional knowledge and judgement in relation to his patient. It is signed by a licensed dentist and contains data and/or details regarding one or more aspects of the dental condition, treatment or health of a patient (i.e. examination data, treatment planning data, treatment rendered data, treatment prognosis, and/or treatment limitations).

It may vary in length from a few words written on a preprinted form letter to a multi-page, detailed, technical, complete case history and review. It may be used as a legal document or in conjunction with third party reimbursement to the patient. It is most often a detailed description of the clinical condition of a tooth or teeth at the time of initial examination.

The type of expertise letter provided is dependent upon to whom it is being sent. For example, a court ordered letter of expertise must provide sufficient detail to allow judgement by court officials. This legal document should provide great detail.

In some third party cases a letter of expertise may be requested in lieu of radiographs. As such, it should detail the clinical condition of the tooth/teeth which require treatment at the time of initial presentation by the patient or at the time of the report.

Comment:

Letters of expertise should never give reasons or justification for treatment. They should, however, provide a consultant with information of sufficient detail to allow him to determine benefits which are provided in the contract.

FEE-FOR-SERVICE

Definition:

The traditional method of billing by dentists in private practice whereby the dentist charges for each dental service performed.

The following terms are offered for clarification:

Usual Fee is that fee ordinarily charged for a given service by a dentist.

A fee is customary if it is in the range of the usual fees charged by dentists of similar training and experience for the same service within the same province.

A fee is reasonable if it meets the above criteria or, in the opinion of the provincial dental association, is justifiable considering the special circumstances or the particular case in question.

Comment:

CDA believes that the fee-for-service method has proven over the years to be an efficient and equitable method of financing high-quality dental care.

FRANCHISED DENTISTRY

Definition:

Refers to a system of marketing of a dental practice, usually under a trade name, where permitted by provincial law or regulations. In return for a financial investment or other consideration, participating dentists may also receive the benefits of a national referral system and management consulting services.

Comment:

CDA believes that patient treatment or referral for treatment should not in any way be limited by considerations such as availability within a franchise operation or other business consideration.

**HEALTH MAINTENANCE ORGANIZATION (HMO)/
HEALTH SERVICE ORGANIZATION (HSO)**

Definition:

An organized system of health care that accepts the responsibility of providing and ensuring the delivery of an agreed upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a geographic area, and which is reimbursed through a pre-negotiated and fixed periodic payment made by, or on behalf of, each person or family unit enrolled in the plan.

Comment:

Dental services provided by HMOs/HSOs are organized in three different ways:

Staff Model - An HMO/HSO providing dental services through salaried dentists.

Direct Contract - An HMO/HSO providing dental services through direct contracts with private practitioners.

Individual Practice Association (I.P.A.) - A group of independent dental practices joined together as an association to provide specified dental services to an HMO/HSO.

INDEMNITY PROGRAM

Definition:

Provides specific cash payment reimbursement for specified covered services. Payments may be either to enrollees, or on assignment directly to the dentist.

Comment:

CDA believes that it is in the best interest of both the patient and the dentist for the dentist to receive payment directly from the patient.

INSURED

See Certificate Holder.

INSURER

See Third Party.

MAXIMUM BENEFIT

Definition:

The maximum dollar amount allowed toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year, under a prepaid dental contract.

MEDIATIONS COMMITTEE OF A PROVINCIAL DENTAL ASSOCIATION

Definition:

A committee which generally gathers information and makes recommendations regarding any dentist's or patient's or prepaid dental plan carrier's misunderstandings or problems which may arise with respect to dental treatment, and which is designed to promote understanding, agreement and voluntary resolution of the situation.

NOT-FOR-PROFIT THIRD PARTY

Definition:

A health service corporation or prepaid plan incorporated under provincial statutes regulating not-for-profit corporations, often including dental care.

OFFICE VERIFICATION

Definition:

This box on the Standard Dental Claim Form provides room for the signature of the dentist or a designated employee. This signature indicates the dentist's confirmation that all information which he or she has included in the form is correct.

Comment:

In those provinces which allow it, a signature stamp for verification, it will be placed here. However, the dentist must realize that he is fully responsible for any claim form emanating from his office that has been verified.

PARTICIPATING DENTIST

Definition:

Any dentist with whom a dental service corporation has a contractual agreement to render care to covered subscribers, as in a capitation or Preferred Provider Organization (PPO) system.

Comment:

The CDA strongly recommends that any dentist seek legal advice prior to entering into any contractual agreement. Discussions should also be initiated with your provincial association or licensing board.

PEER REVIEW

Definition:

In the opinion of the Canadian Dental Association, three separate concerns are lumped together under "Peer Review". These are: (a) Dental Prepayment Advisory Services; (b) Mediations Services; and (c) Peer Review.

(a) Dental Prepayment Advisory Services

These are services which assist in understanding policies, resolving management or administrative questions, and discussing matters of mutual interest. They may be available to individuals, groups, or constituted organizations.

(b) Mediations/Arbitration Services

Mediations/arbitration services are designed to resolve misunderstandings or disagreements between or among patients, third party insurers, governments and dentists.

(c) Peer Review

Peer review is an evaluation and judgmental process involving assessment of competence, ability to diagnose, plan and perform services. Its consideration includes analysis of ethics, assessment of quality of practice, and of quality and quantity of services performed. It is conducted by one or more individuals with comparable training, competence, and knowledge to those of the dentist being reviewed. Under provincial dental legislation peer review is the exclusive responsibility of the provincial licensing board.

Comment:

CDA believes that each of the above committees can play a valuable role within the provincial dental association.

PIGGY BACKING

Definition:

A prepaid plan concept which provides any additional service to its enrollees, such as dentistry, for a nominal additional premium, is said to be "piggy backing" this additional service.

PRE-AUTHORIZATION

See Pre-determination.

PRE-DETERMINATION

Definition:

An administrative procedure under an indemnity-type prepaid program whereby a treatment plan is submitted to the third party before treatment is initiated. The third party returns the treatment plan indicating one or more of the following: patient's eligibility, guarantee of eligibility time, covered service amounts payable, application of appropriate deductibles, co-payment factors, and maximums. It is intended that this be done on a case-by-case basis.

Comment:

CDA believes that it is prudent for the dentist to wait an appropriate length of time prior to commencing any major crown/bridge, full or partial denture service. This courtesy allows the patient sufficient time to know their benefits and to make an informed decision on the proposed treatment involved, taking into consideration not only the suggestion of the provider of service, but also the economics of the situation. However, pre-determination does not guarantee payment; the contract must be in force at the time of service. Treatment plans may change with time and, therefore, we suggest all parties be aware that this is subject to change after three months.

PREFERRED PROVIDER ORGANIZATION (PPO)

Definition:

A system wherein the employer or the third party insurer contacts a number of dentists and offers to include the names of these dentists as "preferred dentists" on a list to be distributed to the insured employees (patients). In return for this listing, the dentist must agree to a reduced fee schedule for any of these patients whom he might treat. This reduced fee schedule may take the form of a percentage reduction of the practitioner's normal fee or it may take the form of a flat table of allowances for the services. The patients are under no obligation to go to the providers on this list, therefore they retain "freedom of choice".

PREPAID DENTAL PROGRAM

Definition:

A program that contracts through a third party to finance the cost of specified dental care.

Comment:

Dental "insurance" is a misnomer for prepaid dental plan. The concept of insurance is based on a large number of subscribers paying a low premium for protection against an unlikely, costly, unwelcome or disastrous occurrence. Dental disease is universal and it is certain that most subscribers will demand reimbursement for dental expenses during any given year. Thus, dental coverage is cost-averaging, based on reimbursement of all claimants from pooled monthly premiums. Cost-averaging is prepayment, not "insurance".

PREMIUM (INDEMNITY)

Definition:

The amount charged by a third party for coverage of a specified period of time and level of benefits. (See also Capitation Payment Methods - Premium.)

PREPAID INDEMNITY PROGRAM

See Prepaid Dental Program.

PROOF OF LOSS

Definition:

Verification of expenses incurred and/or services rendered under an indemnity-type prepaid program.

Comment:

Please note that the signature of the provider of services is not a requirement to allow payment and as such, the CDA Standard Dental Claim Form does not specifically require the dentist's signature. This does not release the attending dentist from responsibility for the accuracy of all information contained in the dentist's section of the claim form and some provincial jurisdictions may require a signature.

QUALITY ASSURANCE

See Peer Review.

SIGNATURE ON FILE

Definition

A cardex system may be maintained by the dentist of patient signatures on one of two standard forms: "Authorization to Release Information" and "Authorization to Pay Benefits Directly to the Dentist".

Comment:

Not all provinces allow this.

SUBSCRIBER

Definition:

The person, usually the employee, who represents the family unit in relation to the dental program. Also may be called certificate holder, enrollee or insured.

SUPPLEMENTAL PLAN

Definition:

The supplemental plan is a financial plan offered by a closed panel which makes up the difference between the percentage of dental costs covered by a dental plan and 100% of the dentist's usual fee. Payment at 100% is only available if the services are provided at the sponsoring dental office.

Comment:

CDA believes that supplemental dental plans present the same potential disadvantages for patient care as outlined in the comments under capitation.

SUPPLEMENTARY INFORMATION REQUEST

Definition:

A request from the prepaid dental plan carrier to the dentist to clarify information submitted on the claim form or the treatment plan form.

SURCHARGE

See Capitation Payment Methods.

TABLE OF ALLOWANCES

Definition:

A list of covered services in an indemnity-type prepaid contract that assigns to each service a sum which represents the total obligation of the plan with respect to payment for such service, but which does not necessarily represent the dentist's full fee for that service. Also may be called schedule of eligible benefits.

THIRD PARTY

Definition:

The party to a dental prepaid contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services. Also may be called administrative agent, carrier, insurer, underwriter.

TREATMENT PLAN

Definition:

A general listing of prescribed dental services, plus an estimate of the cost of these services, which is given to the patient by his dentist. All basic services are given as total categories with total fee estimates and "other than basic" services are outlined in reasonable detail with individual fees, as well as approximate laboratory charges.

"Reasonable detail" implies that the actual description of the "other than basic service" is to be provided. Be reminded that, in third party cases, this form will be viewed by the carrier to determine liability. The more detail provided, the more informed the patient will be about financial considerations, and the sooner the third party carrier can respond to the request for pre-determination of benefits.

The treatment plan should include the approximate laboratory charges for procedures to be pre-determined. This will allow the patient a better idea of the total cost of the procedure, not just the professional fee.

UNIQUE NUMBERING SYSTEM

Definition:

A nine digit numbering system to identify individual Canadian dentists. Each of the digits has a specific meaning. (See Appendix I).

UTILIZATION

Definition:

The extent to which the members of a covered group claim benefits over a specified period of time. Also less frequently defined as the number of services claimed per year.

WAITING PERIOD

Definition:

The period of time between the date of commencement of employment or of enrolment in a dental program and the date when a participant becomes eligible for specified benefits.

That time between the date a treatment plan is presented to a patient and the date when treatment is actually commenced.

Comment:

CDA suggests that in cases of third party coverage, it is the prudent dentist who waits an appropriate length of time to allow processing of the treatment plan by the carrier. Following this suggestion will preclude the possibility of treatment X-rays in a post-treatment situation and will also reduce requests for data by third party carriers.

CANADIAN DENTAL ASSOCIATION POLICIES

These policies utilize and are based on the specific terms as defined in the CDA Glossary of Terms concerning prepaid dental plans and alternate delivery systems.

1. Dental Services Performed by Auxiliaries

Dental services properly rendered under the supervision or direction of a dentist by an auxiliary operating within legal limits are valid dental services to a patient, regardless of whether he has or does not have a prepaid dental plan. If a dental service is "covered" by a plan, it is "covered" regardless of whether the dentist or his auxiliary renders the service.

2. The Dentist-Patient Relationship

This is an inviolable contract between two parties that does not permit the intrusion of a third party except by mutual consent of both parties, or by legal requirement. Agreement to allow limited intrusion into this relationship when the third party is a carrier should be allowed only within the guidelines contained in this manual.

Intrusion into the dentist-patient relationship occurs most frequently in an assignment of benefits situation, or in Preferred Provider Organizations (PPOs). The Canadian Dental Association does not recommend participation in these programs.

Where a capitation/closed panel prepaid dental plan is offered within your province and in order to preserve individual freedom of choice to all subscribers and dentists involved with the program, the CDA recommends that the option must exist for the subscriber to enroll either in the capitation/closed panel program or an indemnity prepaid dental plan with equal premium dollars available on an individual enrollee basis for the program of the subscriber's choice. The CDA recommends that any dental plan should ensure freedom of choice for both the patient and the dentist.

3. Fee-for-Service

Each dentist should charge his usual and customary office fees, regardless of any third party reimbursement to the patient. These fees charged for services performed should be arrived at as per the preamble of your provincial fee guide, also taking into consideration the opening remarks in this manual.

The CDA continues to believe that the waiving of a copayment factor in cases of third party reimbursement is unethical, if not fraudulent. The waiving of a copayment will ultimately lead purchasers of dental plans to instruct carriers to keep reimbursement at the same levels year after year, contract after contract. Patients accustomed to having the copayment factor waived will be very reluctant to pay anything, even if the copayment factor is not a high amount.

4. Mediations/Arbitration and Peer Review

Where questions regarding communication or misunderstanding in relation to treatment, diagnosis or other areas arise, the matter should be submitted to the appropriate committee of the provincial association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee, for careful review and an impartial opinion.

If the problem is one of quality of treatment, improper treatment, misdiagnosis, or other areas of a legal or a licensing regulation infringement nature, the matter in question should be submitted to the Provincial Dental Licensing Board.

An individual hired by a third party is not acceptable as a mediator or judge in these areas.

The Canadian Dental Association does not recognize the right of prepaid dental plans, and/or their agents, representatives or consultants, to perform any function of peer review.

5. Patients' Needs

Dentists are concerned with the well-being of their patients. A prepaid dental contract and its provisions must not be the sole determining factor as to which procedures are performed.

The dental health of the patient must be foremost in the mind of the dentist and the patient must be made aware of this philosophy.

6. Payment Assignment (indemnity programs)

The CDA does not recommend the acceptance of assignment of benefits by the patient to the dentist. Assigned payments directly to dentists will eventually lead to pressures from carriers and ultimately CONTROL OVER OUR PRACTICES BY OUTSIDE AGENCIES.

The CDA has repeatedly reminded our members of this problem. The following represent the most obvious of the problems insidious to the use of assignment:

- (a) Assignment can destroy the dentist-patient relationship. The patient's concern with the treatment plan and the services rendered can be greatly diminished.

- (b) If the patient is not responsible for the fees charged, he may not be particularly interested in the treatment planned or services rendered. As well, he/she may be less inclined to carry out important daily oral hygiene procedures to maintain or improve good oral and dental health.
- (c) The collection of accounts receivable is no longer solely under the control of the dental office. The carrier may elect to forward payment at any time or delay the payment of account for as long as possible. As the dental office has no control over this area of the carrier's administrative procedures, it has no control over this aspect of its own A/R balance. In co-payment situations it is often far more difficult to collect the balance of the account from a patient who has little interest in the dentistry which has been provided, particularly as these services have been rendered some time previously. It is important to note that normal office procedures for the collection of patients' accounts must be carried out in all cases. Regardless, in-office cash flow may become a serious difficulty with assignment of benefits.
- (d) The Canadian Dental Association's Third Party Dental Plans Committee is becoming aware of an increasing number of cases in which prepaid carriers are REFUSING to accept the assignment of benefits to PARTICULAR dentists in cases of high suspicion, when patient audits and dentist profiles indicate areas of concern.
- (e) The dentist on assignment is more vulnerable to improper requests from the carrier. Your rights and legal obligations are outlined under provincial dental legislation. By fulfilling or complying with improper carrier requests, the dentist involved is often surrendering these rights and/or compromising or even jeopardizing his legal position with the Dental Licensing Board of his province.

The CDA recommends there should be no difference in the dollar amount paid by the prepaid dental plan or in the time taken to remit said payment, regardless of whether the reimbursement is paid to the patient, or directly to the dentist via a system of assignment which approximates the endorsement of a cheque by the patient (or parent/guardian).

7. Promotion

The promotion of any third party plan must not be in conflict with the Code of Ethics of the CDA or your Provincial Dental Association. Certain clauses within dental plan master contracts have resulted in the dentist believing he must justify his treatment or treatment plan. Clauses of this sort (for example, Alternative Benefit Clauses and pre-existing condition clauses) are frowned upon by the CDA. It is the opinion of the CDA that these clauses require dentists in Canada to contravene our guidelines.

8. Radiographs and Study Models

Preamble

Radiographs, along with a clinical examination, provide the basis upon which the dentist makes a complete oral diagnosis. These radiographs are a part of the clinical record. According to provincial dental legislation, these records must be maintained for the required number of years and, following the death of the dentist, they must be maintained by the dentist's estate for the required period of time. If the patient changes from one dentist to another, these records may be transferred according to the normal professional procedure and upon the request of the patient.

The Canadian Dental Association has expressed its concern that dental patients should not be exposed to X-radiation for the sole purpose of the verification of eligibility for dental insurance benefits or confirmation of treatment completed. This position was communicated to: the dental profession across Canada; federal and provincial Ministries of Health; third party insurers of dental services; federal and provincial superintendents of insurance; federal and provincial regulatory bodies concerned with administration of X-radiation; and the Consumers Association of Canada.

Carriers' Responsibilities

Carriers have a contractual responsibility to clients to provide reimbursement for dental care according to the terms of the contract between the carrier and the subscriber/patient. Some contracts may contain an Alternate Benefits Clause permitting reimbursement for "the least expensive professionally adequate treatment plan". Thus, payment may be limited to the fee for a partial denture even though a fixed bridge was inserted. All contracts require a carrier to make efforts to ensure that fees are paid for services actually rendered. Some carriers attempt to determine which services they deem to be required by the patient.

Most contracts have co-payment clauses or limitations on certain procedures. The co-payment clause usually permits reimbursement to a certain percentage of the fee charged. The limitation clause may permit a carrier to reimburse for a service only under certain conditions.

The carriers require information from the dentist to properly determine liability to the subscriber/patient. Such information must be used carefully by the carrier in order to avoid improper practices, such as making a diagnosis concerning the patient's requirements based solely on this information. On occasion in the past, carriers have communicated to the subscriber/patient in a manner unacceptable to the dental profession. Such communications include inferences that the dentist is providing

services to the patient that may be unnecessary. A carrier may only inform the patient that coverage, according to the terms of the contract, is limited to certain procedures. A carrier cannot recommend that an alternative treatment plan be followed.

CDA Statement on Release of Radiographs

The Canadian Dental Association has adopted a policy to identify what type of information should be included in a treatment plan and the timeframe for the submission of this plan to a third party carrier.

Regardless of the reimbursement levels enjoyed by the patient from a benefit plan, the decision concerning dental care should be based on information provided by the dentist to the patient. The economic implications of a treatment plan must be considered by the patient, and the decision to proceed with any given plan rests with the patient.

For this reason, the CDA strongly recommends, particularly when prosthetics or extensive treatment is proposed, that dentists assist their patients by providing a completed treatment plan which will be submitted to the carrier. With the treatment plan, the carrier will be able to determine the amount of reimbursement which the patient will receive once treatment has been completed.

In treatment plans where inlays, onlays, crowns and/or bridges are planned, treatment radiographs should be made available at the written request of the carrier's dental consultant. To our knowledge, there are no other circumstances in which dental plan carriers need or should receive dental radiographs.

The advantages of pre-determining patient benefits cannot be over-emphasized. Carriers have responsibilities under the terms of their contracts and must fulfill them. If pre-determination procedures are not followed, carriers will invariably request radiographs when the claim is presented as an aid in determining their responsibilities. It is then too late to obtain a second professional opinion concerning the treatment plan because work has been completed and the circumstances leading to the decision of a treatment plan cannot be duplicated. Even an assessment of the treatment radiographs at this stage is not particularly useful and the patient may become involved in differences of opinion between the treating dentist and the dental consultant for the carrier.

In cases where pre-determination procedures are not followed, for whatever reason, the carrier, patient and dentist may encounter problems. The carrier may decide not to reimburse the patient until more information is obtained. The patient may or may not have paid the

dentist his professional fee, but will no doubt be upset if reimbursement is not forthcoming from the carrier. Regardless of where the blame lies for the lack of pre-determination, the patient will invariably consider the dentist at fault for not complying with the carrier's wishes.

The CDA recommends that, in these circumstances, a member provide an expertise statement to the carrier, describing the information obtained from interpreting the radiographs. However, not all carriers accept these statements. If an impasse occurs, the dentist should contact the appropriate committee of the provincial association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee.

Carriers can, and have, requested radiographs for procedures other than inlays, onlays, crowns and/or bridges. The reason for these requests is unknown to us, but it is generally accepted that such evidence is not necessary for determination of liability. In our view, this is not a legitimate request if the evidence is required to form an opinion on a treatment plan. Diagnosis and treatment are vital aspects of dental practice and, according to our interpretation of the law, comment on such diagnosis and treatment is considered to be peer review, a right enjoyed only by the Dental Licensing Board of the province.

Despite our views on this matter, many members routinely submit radiographs to carriers upon request, regardless of the propriety or legitimacy of this request. A dentist may wish to assist his patient and avoid any conflict; however, each time a member submits to such a request, it is a stimulus for further requests from that carrier. As we have proven with the development of standard claim forms and other beneficial policies, the only way to achieve our common objectives is for all members to support them and to adhere to our policy guidelines.

9. **Responsibility of the Dentist**

Dentists are responsible for the performance of services, as required under provincial dental legislation and as authorized by their patients. CDA recommends that dentists deal directly and only with the patient, regardless of any third party involvement.

However, the dentist should make an attempt to aid his patient in understanding his third party coverage, making the patient aware that acceptance of proposed treatment is ultimately the patient's responsibility. Proposed treatment and covered benefits may not necessarily be the same and it is up to the dentist to make the patient aware that this may be so. The dentist is also responsible for providing the patient with information detailing procedures and costs - usually in the form of a standard claim form.

10. Responsibility of the Patient (or parent or guardian)

Only the patient may authorize the performance of dental services and is, therefore, solely responsible for the arrangement of payment for these authorized services. The patient must ensure that the carrier is furnished with the necessary information which will enable processing of claims, i.e. Part 1 of the claim form from the dentist and Parts 2-4 properly and fully completed by the patient or his/her employer.

Delays in processing claim forms invariably occur because one or more of these areas is improperly completed. Patients must be fully aware of these requirements.

11. Third Party (Parties)

No dentist should enter directly into a contractual arrangement with a third party which would infringe on his legal rights or those of other dentists to practise dentistry as outlined under provincial dental legislation. No dentist should enter directly into a contractual arrangement with a third party which infringes on the sanctity of the dentist-patient relationship.

The Canadian Dental Association does not recognize the right of third parties to approve dental treatment, or to suggest courses of treatment which are alternate to those recommended to the patient by his dentist. The CDA contends that the process of pre-determination relates only to the subscriber-third party relationship in determining the approximate amount of reimbursement benefits available to the subscriber for the proposed treatment services. This approximate amount of reimbursement can only be secured when a properly completed treatment plan form is made available to the patient for pre-determination purposes.

12. Treatment Form/Claim Form

Dentists voluntarily cooperate in providing the patient with a CDA Approved Standard Treatment Form and applicable fee estimate. Upon the patient/subscriber's request, dentists also voluntarily cooperate by providing a properly completed CDA Approved Claim Form as described in the Instruction section of this manual. Once the patient has signed the claim form it becomes a statement of proof of services performed to forward to the third party.

The dental parts of the written CDA Claim Form should be completed by the dental office for the patient, at no charge. A charge, agreed to in advance and commensurate with the time and complexity involved, should be considered for the preparation of all additional reports.

Referrals of claims or treatment plans by third parties to their dental consultants for evaluation must relate only to the extent of the carrier's liability in payment of claims.

GUIDELINES FOR DENTAL CONSULTANT ACTIVITY

A. Definitions

The Glossary of Terms at the beginning of this booklet is an integral part of these guidelines for Dental Consultant Activity.

A dental consultant is a licensed dentist who is retained by an entity providing or administering government or private prepaid dental plans to give the benefit of his expert professional advice in the administration of that program.

B. Qualifications

1. Must be a duly licensed dentist in Canada.
2. Should be duly licensed by, and a resident member in good standing, of the Provincial Licensing Board or Provincial Dental Association in the province in which the claims originate and conduct himself in accordance with the provincial dental legislation.
3. Should be a general practitioner or specialist in that province in active private practice for at least ten years, and should continue to be in part-time private practice himself while consulting. If a specialist, he should only consult on, and be limited to, his own specialty.
4. Should be an active member in good standing of his local dental society, the Provincial Dental Association, and the Canadian Dental Association.
5. Should have better than average knowledge of current dental therapeutics, techniques and materials, and expertise in radiographic interpretation through continued dental education.
6. Should be well-respected by the profession, particularly in his own dental community.
7. Should be a dentist having high moral and ethical values, strong character, and be able to work well in stressful situations.
8. Should have experience in third party dental activity, such as Mediations, Dental Practice Advisory, or similar committees.
9. Should be willing to consider differing opinions and seek specialist input when indicated.

10. Should be able to communicate with other dentists in a tactful but positive manner.
11. Should be able to serve as a teacher to other personnel in interpreting contract language, dental terminology and general knowledge about the practice of dentistry.
12. Should be willing to have the carrier file his name with the Provincial Dental Association prior to commencement of employment, to prevent any potential conflicts of interest in the association and to allow confirmation that the consultant dentist is licensed in that province.

C. Compensation

It is hoped that the compensation negotiated between the dental consultant and his employer would be such as to attract the best qualified personnel.

D. Background

To properly carry out the duties of a dental consultant, he should be thoroughly knowledgeable in the following:

1. the contract language of the program for which he will be functioning;
2. the proper and ethical standards of dental treatment which is expected of every dentist in the province from which the claim originates;
3. the provincial dental legislation;
4. laws governing dental care programs, e.g. Insurance Code, corporation codes, etc.;
5. the Code of Ethics/Conduct of the Provincial Dental Association, the Canadian Dental Association and the Dental Licensing Board of the province, if applicable;
6. the benefit brochures of the subscriber/insured/enrollee;
7. the policies, guidelines and systems of the CDA and the Provincial Dental Associations re: prepaid dental plans;
8. the Terms of Reference and function of the Dental Practice Advisory and Mediations/Arbitration committees of the Provincial Dental Association, and the peer review mechanism of the Provincial Licensing Board of the Province.

The employer, carrier, or prepaid plan administrator should be responsible for keeping on hand in the company library, all the above specified documents, and to update these items at regular intervals and maintain them for easy access and reference by the dental consultant.

E. Responsibilities of the Dental Consultant

At all times, the patient's health and well-being is the primary concern of all involved.

As far as the actions and activities of the consultant are concerned, there should be no conflict with the policies of the CDA and Provincial Dental Association, and no intrusion into areas which are the legal purview of the Dental Licensing Board of the province from which the claim originates.

NOTE: In cases of infringement upon the rights and privileges of the attending dentist, the attending dentist may have legal recourse to the actions of the dental consultant and/or his employer.

F.I Responsibility of the Dental Consultant to his Employer

- (a) To assist in the evaluation of statistical data to detect possible abuses, or patterns of abuse of the program by either providers of care, patient/insured or the carrier. This could involve internal profiling of dentist's claims.
- (b) To recommend to the carrier that it seek the assistance of the dental profession, where indicated, either via the appropriate committee of the provincial association (such as the Mediations/ Arbitration Committee or the Dental Prepayment Advisory Committee), or the peer review mechanism of the Dental Licensing Board in that province, as appropriate to their respective areas of purview. (See definitions in Glossary of Terms.)
- (c) To aid in the public and professional relations of the employer with the beneficiaries and the dental profession.
- (d) To advise in areas of program design and benefit structure.
- (e) To teach and advise dental prepaid plan administrative staff concerning those professional matters that will enable them to function properly and efficiently, but not to include any matters or areas that are the legal purview and responsibility of a licensed dentist. The areas of responsibility should include:
 - (i) The design and evaluation of printed forms, memos, and form letters which will emanate from the carrier as to content, clarity, and possible areas of misunderstanding and conflict. This should be done in cooperation with the appropriate committees of the Canadian Dental Association and the Provincial Dental Associations and should include the development of the format and wording for expertise letters and other written communications for the purposes of eliciting additional information or responding to claims inquiries either from the patient or the dental office.

- (ii) The instruction in dental nomenclature, etc. of those personnel who will be required to use it.
- (iii) The scope of authority of the lay personnel must be clearly defined to avoid those matters under the purview of a licensed dentist.
- (iv) Advise personnel who may be handling dental records as to their proper care and handling (e.g. radiographs, study models, photographs, etc.).
- (f) To be prepared to explain or interpret the provisions of the contract to the subscriber/insured/enrollee.
- (g) To work with the Third Party Dental Plans Committee of the Canadian Dental Association, the Prepayment Advisory Committee or the Mediations/Arbitration Committee of the Provincial Dental Associations in any and all areas of mutual concern or interaction.
- (h) The consultant is encouraged to keep a reference file of relevant articles on prepaid dental plans.
- (i) To request clarification of poorly or improperly completed information.

Under indemnity-type prepaid dental plan programs, the following responsibilities may be included:

- (a) to assist in the pre-determination of benefits and the determination of liability according to the terms of the indemnity prepaid plan contract;
- (b) to avoid an arbitrary imposition of a substitution clause concept;
- (c) to aid in the processing of claims.

F.II Responsibilities of the Dental Consultant to the Patient and/or Purchaser

- (a) To assure the patient the maximum possible reimbursement under the terms of the contract without interfering in the course of treatment mutually agreed upon by the patient and attending dentist. To assist the consultant with this, the plan should be absolutely explicit and clear in the wording of all its clauses. Under indemnity programs, the consultant should consider the concept of payment for alternate treatment towards services not covered in the prepaid plan contract to assure maximum possible reimbursement.
- (b) Mediations or peer review are not a responsibility. The patient should be referred to the appropriate dental organization.

- (c) To place the patient's welfare before purely financial considerations.
- (d) To protect the prepaid plan purchaser from program abuse, or fraud, by initiation of appropriate investigations by the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee of the Provincial Dental Association or by the Dental Licensing Board of that province.
- (e) Where, in the opinion of the dental consultant, diagnostic aids submitted for pre-determination of company liability indicates unequivocally the potential for improper treatment if the treatment plan is carried out as presented, a comprehensive written report should be forwarded to the appropriate committee of the provincial dental association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee.

F.III Responsibilities of the Dental Consultant to the Patient's Dentist

- (a) To avoid interference in the dentist/patient relationship, the consultant should refrain from taking any direct action that could undermine the patient's confidence in either his attending dentist or the dental treatment.
- (b) To determine from submitted information, only those facts that can be properly determined from such information.
- (c) To promote efficient handling of claims, processing, and payment procedures under indemnity-type prepaid programs.
- (d) To write to the attending dentist when there is a lack of understanding. Brief expertise letters are preferable. If telephone or verbal discussions are unavoidable, a follow-up written summary should be forwarded to the dentist.
- (e) To fully recognize his own limitations. That is, to be willing to seek the opinions of other qualified practitioners, including specialists, when indicated. The individuals should be employed by the carrier on a part-time basis.

Consultation with individuals not employed by the carrier should be discouraged in order to avoid breach of confidentiality of health records and maintain the dentist/patient relationship.

F.IV Responsibilities of the Dental Consultant to the Dental Profession and to the Public

- (a) To endeavour to follow all guidelines and policies of the Canadian Dental Association and the Provincial Dental Association which apply to, or are related to, prepaid dental plans in the province where the treatment is being rendered.

- (b) To initiate, on behalf of the carrier, an investigation by the appropriate agency (see below) when he feels there is valid indication for same.
 - (i) The Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee of the Provincial Dental Association.
 - (ii) The Third Party Dental Plans Committee of the Canadian Dental Association.
 - (iii) The Complaints Committee of the Dental Licensing Board of that province.

At the same time, the attending dentist should be informed of the actions being undertaken by the carrier.

F.V The Consultant, the Treatment Form and the Claim Form

An important function of the dental consultant is the evaluation of the treatment plans submitted for pre-determination of benefits, and evaluation of the claim forms submitted for payment when the treatment has been completed. The following are some guides which might aid the consultant in his proper evaluation.

- (a) There will be times when, after proper contact by the dental consultant with the treating dentist, certain differences will still exist. It is at this time that the case should be referred for mediation/arbitration.

When a dispute occurs, it is the responsibility of the consultant to do all that is reasonably possible to resolve it by means of correspondence, use of the appropriate committee of the provincial dental association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee, prior to seeking the aid of the Complaints Committee of the Provincial Dental Licensing Board.

- (b) From time to time, certain problems which are unique will come to the attention of the consultant. These should be communicated to the appropriate committee of the provincial dental association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee, for action. In consultation with representatives of the third party, the committee will attempt to resolve the matter. The Third Party Dental Plans Committee of the Canadian Dental Association is also available to help in these situations.
- (c) The consultant must be objective in cases where modality of treatment might differ from his own. It is not the responsibility of the consultant to have all beneficiaries treated just as he would personally treat them.

- (d) Not all dental offices will adequately enter on a claim form all proper data for claims determination according to the provincial guidelines. In such cases, they should be asked for adequate and proper reporting, without summarily dismissing the claim. Brief expertise letters or reports may be an ideal solution. The consultant should not act in conflict with, or request any data in conflict with, CDA or Provincial Dental Association policies. He may request assistance from the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee of the Provincial Dental Association to achieve the proper result.

The CDA has prepared specific guidelines for dentists when submitting additional information to an insurance carrier at the request of the dental consultant. These guidelines apply equally and similarly to original radiographs and/or study models and duplicate radiographs and/or study models. (See pages 22-24.)

- (e) The consultant's responsibility is to determine the program benefits payable to the patient towards his choice of treatment. The consultant should not interfere between the patient and dentist because they have agreed upon treatment at a level which happens to be beyond the level of the covered benefits.

F.VI The Dental Consultant and Profiling

One of the responsibilities of the dental consultant is to assist in the evaluation of possible abuses of the prepaid plan. The most common method of carrying out this responsibility is by the profiling of claims submitted.

The Canadian Dental Association is aware of this legitimate method of detecting possible abuse. The following guidelines should apply to the use of profiling, as described below.

- (a) The dental consultant should follow the guidelines as outlined in this manual.
- (b) Profiling should only be carried out in response to a pattern of claim submissions which, upon computer or manual analysis, is suspicious of abuses of the prepaid plan.
- (c) It should be recognized that a claims profile may serve to exonerate the particular dentist, as well as implicate him.
- (d) The profile should involve sufficient claims to be considered statistically relevant. One or two unusual or suspicious claims does not constitute a profile.
- (e) There should be no comparison of profiles among carriers or their dental consultants. Any request for profiles should not implicate the dentist involved. (Refer to item (c) above).

Profile information may be submitted in such a way as to protect confidentiality of the patient's health records along with carrier comments of its concerns to the appropriate committee of the provincial association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee, for review. The committee will return the information with any recommendations to the carrier.

- (f) If the evidence obtained in a profile is suggestive of abuse of the prepaid plan, and appears to be in direct contravention to the Provincial Dental Legislation, the profile should be forwarded to the Dental Licensing Board of the province involved for investigation. A covering letter must accompany the profile, outlining the reason for forwarding the profile and the name of the carrier and dental consultant involved.

GUIDE FOR DENTAL OFFICES TO ASSIST PATIENTS WITH INDEMNITY PREPAID DENTAL PLANS

Introduction

**Approved by the Canadian Dental Association, April 1987.
These Guidelines replace all previous manuals.**

These guidelines have been prepared to assist both dentists and staff in dealing with patients who are covered by indemnity-type prepaid dental plans. The CDA/Provincial Dental Association policies on prepaid dental plans and the related glossary of terms with respect to prepaid dental plans are to be considered as an integral part of this section, and should be reviewed with respect to the terminology that is used here.

There are four basic parts to this section of the manual:

- 1. Treatment Plan Form;**
- 2. Claim Form;**
- 3. Supplementary Information Requests;**
- 4. Additional Procedures.**

All forms approved by either your Provincial Dental Association or the Canadian Dental Association should carry the crest and logo of the particular association.

Carriers, administrators, or administering agencies may reject claims from the subscriber/insured if not properly completed on CDA/Provincial standard forms.

All information must be accurate, legible, and complete, according to this manual.

Any prepaid plan carrier, administrator, government agency, or individual dentist wishing to print any CDA Approved Treatment Form, Claim Form, Supplementary Information Form or other form related to prepaid plans which carries the CDA crest and approval MUST SUBMIT A PRINTER'S PROOF TO THE CANADIAN DENTAL ASSOCIATION TO VERIFY ACCURACY AND PROPRIETY. UPON APPROVAL, WRITTEN AUTHORIZATION FROM THE CANADIAN DENTAL ASSOCIATION TO USE THE CREST AND APPROVAL ON THAT FORM WILL BE GIVEN.

Any commercial printing firm wishing to print any CDA approved forms for individual dentists MUST GUARANTEE that it will adhere exactly to the precise specifications and layouts for any forms which carry the approval and crest of the Canadian Dental Association.

If you have any questions concerning any aspect of assisting your patients in dealing with prepaid dental plan programs, it is suggested that you contact the CDA Third Party Dental Plans Committee.

The Treatment Plan

The Third Party Dental Plans Committee's Glossary of Terms defines the treatment plan as "A general listing of prescribed dental services, plus an estimate of the cost of these services, which is given to the patient by his dentist. All basic services are given as total categories with total fee estimates. 'Other than basic' services are outlined in reasonable detail with individual fees, as well as approximate laboratory charges."

Upon his request, the dentist should provide the patient with a written treatment plan and fee estimate on a CDA/Provincial Dental Association approved Treatment Form, as illustrated at the end of this section. This is the dentist's own office form, for all carriers. If a carrier prints the treatment form as a service to dentists, the dentist's section of that form must be exactly the same as the example.

This written treatment plan should also be given to a patient upon request, even if he does not have prepaid plan coverage. It is the prudent dentist who informs his patient of the treatment planned BEFORE the work is commenced, at which time a thorough discussion of fees and payment responsibility can take place.

Where service categories are indicated as "total fee only", enter only that information on the form. Where tooth and fee are indicated, enter BOTH. For other services, including crowns, bridges, dentures, etc., itemize tooth, service, and professional fee, but not the lab charge. Include any in-office laboratory cost in the professional fee estimate, and CROSS OUT THE "+L" on that line (if there are no other out-of-office lab charges), and in bold letters, write "in-office L".

Estimate any commercial laboratory charges for the proposed services, as indicated on the form. The exact commercial laboratory costs are provided at claim time as part of the standard approved claim form.

FOR PRE-DETERMINATION OF BENEFITS, THE TREATMENT FORM SHOULD BE USED. Although we would encourage you to use the treatment form, the Standard Dental Claim Form may be used if "for pre-determination only" is clearly marked IN THE DENTIST'S COMMENTS SECTION.* Treatment plans may change with time and, therefore, we suggest all parties be aware that this is subject to change after three months.

*The Ontario Dental Association does not recommend this practice for its members.

The patient should clearly understand that this entire treatment is an estimate, and that it could vary, usually within a moderate range, but occasionally very widely.

EMPHASIZE THAT IT IS THE PATIENT'S RESPONSIBILITY TO ASCERTAIN THE TERMS OF HIS CONTRACT WITH THE THIRD PARTY. The dentist may try to assist the patient in understanding coverage. However, the specifications

of many plans are complex and difficult to interpret, especially from small brochures or pamphlets and many patients do not remember to bring in such pamphlets.

It is difficult, and beyond the responsibility of any dentist, to advise a patient regarding coverage and reimbursement. Dentists should be cautious in advising patients regarding their prepaid plan coverage.

In all cases involving inlay/onlay, crown, and/or bridge procedures, and also if the patient has any doubt about the plan's liability, the dentist should give the patient a written treatment plan, and recommend that the patient submit it to the carrier to obtain pre-determination benefits.

The patient should complete the subscriber/insured section of the form and forward it to the carrier. The dentist's responsibility ends when he properly completes the treatment form and hands it, or mails it, to his patient.

The patient must be aware of his coverage, deductibles, and co-insurance factors.

THE CANADIAN DENTAL ASSOCIATION RECOMMENDS THAT, WHEREVER POSSIBLE, NO INLAY/ONLAY, CROWN AND/OR BRIDGE TREATMENT BE COMMENCED UNTIL SUCH TIME AS THE PATIENT RECEIVES A WRITTEN CONFIRMATION OF CARRIER LIABILITY.

The prepayment agency will give the patient a general statement of liability regarding all basic services, and a more specific determination of liability (possibly in dollar terms) for crowns, bridges, and removable prostheses. In all cases, exact determination of liability is made only from the claim form, after treatment.

After the patient receives the pre-determination benefits from his carrier, he may wish to discuss the treatment plan again with the dentist. However, the patient should initiate that discussion.

Additional Information Procedure

If any further information (including specific company pre-determination forms, other than your written standard CDA/Provincial Dental Association treatment form) is required, a fee should be considered which must be paid by the patient. If radiographs, study models, etc. are required in treatment situations, follow the CDA/Provincial Dental Association's policy for their provision. Where involved accident or legal cases require any additional information or reports, the dentist must make it very clear before any treatment is commenced, that there will be a fee charged for these written, detailed services which will be proportional to the time involved. Give the patient an estimate of the fee for these reports. Where contracts do not pay for written reports, the patient is responsible and this should be settled in advance.

If there is any concern about the propriety of the information requested by the indemnity plan administrator, consult the appropriate committee of the provincial dental association, such as the Mediations/Arbitration Committee or the Dental Prepayment Advisory Committee.

Treatment and Referral Form Samples

Various standard treatment plan forms and a referral form have been approved by the Canadian Dental Association and various Provincial Dental Associations.

A. Standard Treatment Form

This form is available from several commercial printers under a licensing agreement with the CDA and various Provincial Dental Associations. Your name, address, postal code, telephone number, specialty and unique identification number may be pre-printed on the forms.

B. Standard Pre-determination Form Printed by a Carrier

Some carriers print this form as a service for their subscribers. The dental section of the form must comply exactly with the CDA/Provincial Dental Association format, and no substitutions or alterations are allowed. The subscriber/patient section may vary from carrier to carrier, depending upon their needs, but questions involving dental expertise are not allowed. A printer's proof of any proposed carrier treatment plan form must be forwarded to the CDA or the Provincial Dental Associations for approval, and approval must be granted prior to printing.

C. Standard Dental Referral Form

This form is used by general practitioners who wish to refer a patient to a specialist for treatment. It is meant to ease communication between general practitioners and specialists, but should not replace personal conversations.

D. Standard Orthodontic Information Form for Certified Orthodontic Specialists

PLEASE NOTE: This form is not to be used by General Practitioners.

This form is for use by orthodontists in providing treatment plans for their patients. If general practitioners are involved in providing complex orthodontic treatment for which there is no code in the Provincial Suggested Fee Guide for General Practitioners, the information requested in this form would be considered reasonable if requested by a carrier as supplemental information following submission of a standard treatment form.

If any carrier wishes to print this form as a service for the subscriber/insured, the same guidelines must be followed as for B. above.



STANDARD DENTAL TREATMENT FORM

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Canadian Dental Association

		UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	DATE PREPARED			THIS ESTIMATE IS VALID UNTIL		
					DAY	MO	YEAR	DAY	MO	YEAR
LAST NAME		GIVEN NAME								
ADDRESS		APT.								
CITY		PROV.	POSTAL CODE	DENTIST	PHONE NO.					
					OFFICE VERIFICATION					

ADDITIONAL COMMENTS: Use this space to provide additional information or description pertinent to the treatment plan.

Examination: (Fees Only) \$ +L

Radiographs: (Fees Only) \$

Other Diagnostic Services: (Total Fee Only) \$ +L

Oral Hygiene Instructions: (Fee Only) \$

Other Preventive Services: \$

Prophylaxis/Fluoride: (Fee Only) \$

Basic Restorative Services:

Do not itemize surpluses, fees or teeth here. (Total Fee Only) \$

Surgery: (Total Fee Only) \$ +L

Periodontal Services: (Total Fee Only) \$ +L

Endodontic Services: Tooth \$

(Give Fee per Tooth) Tooth \$

Tooth \$

Tooth \$

Tooth \$

Tooth \$

Anesthetic Services: (Total Fee Only) \$ +Drugs

Orthodontic Services: (Total Fee Only) \$ +L

Other Services including Crowns, Bridges, Dentures: itemize tooth, service, professional fee but not commercial lab charge.

\$ +L

\$ +L

\$ +L

\$ +L

\$ +L

\$ +L

\$ +L

\$ +L

\$ +L

Total Estimated Lab Charges	\$
TOTAL ESTIMATE	\$

L IS AN APPROXIMATION ONLY.
H FINAL LABORATORY CHARGES WILL BE INCLUDED ON CLAIM FORM.

H SERVICES MARKED (H) WILL BE PERFORMED IN HOSPITAL

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THIS SECTION TO BE COMPLETED BY PATIENT			
NAME			
ADDRESS			
EMPLOYER			
ADDRESS			
GROUP POLICY	CERTIFICATE NO.		SOC. INS. NO.
PATIENT'S DATE OF BIRTH	DAY	MONTH	YEAR
RELATIONSHIP TO SUBSCRIBER			
I authorize the release of the information outlined in this treatment form to my insuring company or its agents.			
SIGNATURE OF PATIENT (OR GUARDIAN/PARENT)			

CERTIFIED SPECIALIST IN ORTHODONTICS

STANDARD INFORMATION FORM

Approved by

The Canadian Association of Orthodontists



NAME

ADDRESS

CITY, PROV.

POSTAL CODE

TELEPHONE

NAME OF PATIENT

☐ FULL TREATMENT CASE

☐ LIMITED TREATMENT CASE

BRIEF DESCRIPTION OF CONDITION

Starting date of active treatment

FINANCIAL ARRANGEMENTS:

Preparatory Procedures

Initial Examination ☐ Date: \$

Diagnostic Phase ☐ Date: \$

Treatment Procedures

Initial Payment \$

Monthly Fee ☐ or Quarterly Fee ☐ \$

Other Payment Plan \$

Retention/Observation Fee \$

Estimated Total Fee (if applicable) \$

This is a fee estimate for recommended orthodontic services
These services and fees may vary during treatment.

ADDITIONAL EXPLANATORY COMMENTS:

Date 19

The information on this form is valid
for months from above date.

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SIGNATURE OF CERTIFIED ORTHODONTIST

PATIENT IDENTIFICATION

This section to be completed by Patient/Parent/Guardian

Insurance Carrier

Name

Address

Employer

Address

GROUP POLICY

CERTIFICATE
NO.

SOC. INS. NO.

PATIENT'S DATE OF BIRTH RELATIONSHIP TO SUBSCRIBER
DEPENDANT NO.

FOR PATIENT USE ONLY

FOR PATIENT USE ONLY



**STANDARD DENTAL
REFERRAL FORM**

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

Dear Dr. _____

We are referring:

PATIENT: _____ BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: BUS. _____ RES. _____

REASON FOR REFERRAL:

☐ **CONSULTATION** RE: _____

☐ **TREATMENT** (as requested)

(Please provide specialist with appropriate details of problem, i.e. urgency, areas of concern, using F.D.I. tooth numbering system).

RELEVANT HISTORY:

(Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment).

- ☐ PLEASE CALL THE PATIENT
- ☐ PATIENT WILL CALL
- ☐ AN APPOINTMENT HAS BEEN MADE

- ☐ RADIOGRAPHS ENCLOSED
- ☐ PLEASE RETURN RADIOGRAPHS AFTER USE
- ☐ NOTIFY ON COMPLETION

- ☐ PLEASE REPORT - WRITTEN
- ☐ - PHONE

- ☐ POST REFERRAL MAINTENANCE - ☐ BY SPECIALIST
- ☐ IN THIS OFFICE
- ☐ TO BE DISCUSSED

☐ OTHER RECORDS AVAILABLE

DATE _____

SIGNED _____

Suggestions for Completing Treatment Plans

1. Always keep a copy of any treatment plan for your records. Dentists who wish to order pre-printed standard treatment forms are advised to purchase two- or three-part NCR forms, so that a copy is available.
2. Make sure that the patient/subscriber is aware of the proper method to complete his section. Failure to do so properly will lead to a delay in processing. Each subscriber/insured should have a card with identification numbers and those numbers should be filled in on the form before mailing.
3. Do not mail treatment plans for your patients. It is the patient's responsibility to forward a properly completed treatment plan.
4. Information about purchasing standard treatment forms is available from your Provincial Dental Association.

CDA Standard Dental Claim Form

The Canadian Dental Association and the inter-industry task force of the dental carriers have cooperated to produce a claim form which has changed the dental portion and has standardized the carrier's portion of the form. This form became the standard form as of January 1, 1987 and will be acceptable to all carriers in Canada. It is intended that the dental offices will provide the standard forms and that many carriers will no longer provide forms.

The standard forms (one with lines for manual completion and one without lines for typewriter or computer completion) appear on the following pages.

Instructions for Completing the CDA Standard Claim Form

Part 1 - Dentist

 		STANDARD DENTAL CLAIM FORM	
PART 1 DENTIST		UNIQUE NO. (B)	SPEC. (C)
PATIENT'S OFFICE ACCOUNT NO. (D)		I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORISE PAYMENT DIRECTLY TO HIM/HER SIGNATURE OF SUBSCRIBER	

A. Patient

The dental office must fill out this section to verify for whom the services were rendered.

B.&C. Dentist

Unique No. - The CDA has approved a unique numbering system to identify each dentist. (See Appendix I.)

Spec. - Specialty designation.

Patient's Office Account No. - For computerized practices where you desire a number for the account to readily call it up to pay it.

If you have your own forms printed, B. and C. will be printed. If you purchase blank forms, you may choose to use a rubber stamp.

D. Assignment of Benefits

Some provinces will have the form printed with this box filled in with PLEASE PAY SUBSCRIBER. If this is the case and a cheque arrives made payable to the dentist, he or she should do one of the following:

- return the cheque to the carrier - write on the face of the cheque "Incorrect Payee - please re-issue to subscriber" (no covering letter is required); or
- in certain circumstances it may be necessary to deposit the cheque and issue a new cheque to the carrier for the amount involved.

In those provinces that leave the assignment box open, the patient must sign here for the carrier to send the payment to the dentist.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

(E)

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$_____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

(F)

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

(G)

E. For Dentist's Use Only

This section is for additional information to assist in explaining the services listed on this claim form. Please use this section freely if there is any doubt about the clarity of claim entries.

Duplicate Form

If a patient has dual coverage, please check this box; this will trigger the correct claims administration at the carrier end. It is essential that the dental office check this box when it applies.

F. Patient Signature Box

This provides authorization for the dental office to release claims information and also provides for the patient to sign that he/she is aware that not all charges may be covered.

Signature on File

IN THOSE PROVINCES WHICH ALLOW THE USE OF SIGNATURE ON FILE CARDS, in order for claims forms to be accepted with "signature on file" printed in the sections where the patient/subscriber is to sign, it is necessary for the dental office to establish a system of signature cards with the following statements:

Card 1. Authorization to Release Information

You are authorized to provide the dental plan(s), claim administrator(s) and consulting dental care professionals information concerning dental care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits and should follow the CDA policies and guidelines for information release.

This authorization is valid for three years.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient or Authorized
Person's Signature

Date

Please note that the Canadian Dental Association does not recommend the practice of assignment as it has a negative effect on the patient-dentist relationship.

Card 2. Authorization to Pay Benefits Directly to the Dentist

I hereby authorize payment directly to (dentist's name) of the dental benefits otherwise payable to me.

This authorization is valid for three years.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient or Authorized
Person's Signature

Date

Revocation of Authorization to Pay Directly

The Patient or insured person has the right to revoke the authorization to have the dental plan pay the dentist directly. It is preferred that the insured patient inform the dentist of a revocation directly. If the dentist or the insured patient notifies the carrier of a revocation, such a notice should be in writing. If the revocation is made to the carrier by the insured patient, the carrier should notify the dentist.

If payment has been received by the dentist from the carrier after the dentist has been notified that the authorization to pay directly has been revoked, the dentist should do one of the following:

- (a) return the cheque to the carrier - write on the face of the cheque "Incorrect Payee - please re-issue to subscriber" (no covering letter is required); or
- (b) in certain circumstances it may be necessary to deposit the cheque and issue a new cheque to the carrier for the amount involved.

The signature on file cards are subject to verification from time to time. The verification request should be in writing. If the carrier requests a photocopy of the signature on file cards, they must be provided. It would be expected that no more than one request per three-year period would be made.

Dentist and Carrier Responsibilities

- (a) Carriers and administrators have the right to request in writing and receive proof that valid signatures are maintained in the dental office.
- (b) The dentist is responsible for the maintenance and integrity of the dentist's section of the claim submission, even though the actual processing may be performed by a service bureau, management company, etc.
- (c) Signatures on file should be renewed every three years unless revoked by the patient/insured.

G. Office Verification

This box provides room for the signature of the dentist. In those provinces which allow it, a signature stamp may be used or a designated employee may sign in this box. In future, it may be possible in computerized practices to have a computerized office verification.

DATE OF SERVICE			PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						
02	02	87	01200	36	MODVL	19,999.99	9,999.99	99,999.99
(H)								
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.								
TOTAL FEE SUBMITTED						99,999.99		

FOR CARRIER USE			
ALLOWED AMOUNT	INC	%	PATIENT'S SHARE
CHECK NO.		DATE	
DEDUCTIBLE		PATIENT PAYS	PLAN PAYS
CLAIM NO.			

H. Dental Code and Treatment Data

Date - It is essential that the date be completed.

Procedure Code - Accuracy is essential. Utilize the Provincial Fee Guide for the correct code to designate each individual treatment rendered. For treatments which require multiple appointments (e.g. root canal treatment, prosthesis) only the completion date and one set of codes is utilized.

International Tooth Code (see next page) - A separate line must be utilized for each tooth treated.

I. For Carrier Use

Plan carriers will use this section for administration purposes.

INTERNATIONAL TOOTH CODE

A separate line must be used for each tooth treated.

Permanent Dentition

FIRST NUMBER ON PATIENT'S UPPER RIGHT SIDE "1"								FIRST NUMBER ON PATIENT'S UPPER LEFT SIDE "2"							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
FIRST NUMBER ON PATIENT'S LOWER RIGHT SIDE "4"								FIRST NUMBER ON PATIENT'S LOWER LEFT SIDE "3"							

Primary Dentition

FIRST NUMBER ON PATIENT'S UPPER RIGHT SIDE "5"					FIRST NUMBER ON PATIENT'S UPPER LEFT SIDE "6"				
55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75
FIRST NUMBER ON PATIENT'S LOWER RIGHT SIDE "8"					FIRST NUMBER ON PATIENT'S LOWER LEFT SIDE "7"				

The designation for supernumerary teeth is "99" and requires comment as to location under the additional information section for dentist's use only.

Tooth Surfaces Column - When indicating surfaces repaired in restorations, use only the following specific letters, as printed in bold capitals.

I	Incisal
O	Occlusal
M	Mesial
D	Distal
V	Vestibular (replaces B for Buccal and L for Labial)
L	Lingual

The additional comments section of the claim form may also be used to further clarify which cusps are being replaced.

Tooth Surfaces Column - This column will also be utilized to designate UNITS OF TIME.

Units of Time

Provide the number of units of time taken to perform a service ONLY when the fee guide lists the service with a "per unit of time" following. This information should be placed in the tooth surfaces column or in the additional comments section of the claim form.

DO NOT PROVIDE UNITS OF TIME FOR ANY OTHER PROCEDURES.

Remember that a unit of time is defined as a 15-minute interval. Any fraction of a time unit should be designated as such.

Dentist's Fee

Use the "Dentist's Fee" column only when both a professional fee and a commercial laboratory charge are involved in a service or procedure.

Laboratory Charge

You **MUST** separate the commercial laboratory charge from the dentist's professional fee. They must be entered in their respective columns.

When several commercial laboratory charges occur for one service, as in a denture, the laboratory charges are to be consolidated into one total laboratory charge.

Use the laboratory charge column where a commercial laboratory charge, and therefore a separate professional fee, is involved. Do not place in-office laboratory charges in this column.

Only commercial laboratory charges substantiated by a proper invoice from your dental laboratory should be charged under "Laboratory Charges".

Never round off a commercial laboratory charge to the nearest dollar. Always charge your patient the laboratory charge to the penny, and mark the claim form accordingly.

It should not be necessary to send originals, or copies, of commercial laboratory invoices to any prepaid plan administrator or carrier. The claim form is your complete legal certification of those commercial lab charges.

Extra Expenses - Use the laboratory charge column where an extra expense is incurred for those procedures which have "plus E" in the provincial fee guide.

In-office Laboratory Services

In-office laboratory services are indicated under "Dentist's Fee" on the line immediately following the service to which it applies. Procedure code 99350 is used.

Total Charge

Use the "Total Charge" column for the fee entry where no "Laboratory Charge" and separate "Dentist's Fee" are involved in a service.

Where there is a single professional fee and a single lab charge shown in their respective columns, the sum of the two is entered in the "Total Charges" column on the same line.

Where, for example, a bridge or similar laboratory-involved procedure requires the listing of several teeth and/or procedure codes on separate lines with individual professional fees in the "Dentist's Fee" column, the last line of the series will show the total commercial laboratory charge in the "Laboratory Charge" column and the total charge for the entire procedure (e.g. the entire bridge) in the "Total Charge" column.

Blocking Out Unused Lines

Use two ink "Xs" to cross out all remaining unused lines of the procedure code column and the total charge column to prevent any improper "additions".

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.

IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2, AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.

IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____
 EMPLOYER _____
 NAME OF INSURING AGENCY OR PLAN _____

1. PATIENT: RELATIONSHIP TO EMPLOYEE/
PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____
DAY MONTH YEAR

IF CHILD INDICATE STUDENT ☐ HANDICAPPED ☐

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP
INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO ☐ YES ☐

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN
ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO ☐ YES ☐

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT?
GIVE DATE OF PRIOR PLACEMENT AND REASON FOR
REPLACEMENT NO ☐ YES ☐

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF
THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION
GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____

1. DATE COVERAGE COMMENCED	DAY	MONTH	YEAR	4. CONTRACT HOLDER		
2. DATE DEPENDENT COVERED						
3. DATE TERMINATED						

DATE		
DAY	MONTH	YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

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ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

Although this section is on the preprinted form or that produced by your computer to be a CDA standard claim form, it is not the responsibility of the dental office to complete it. However, it is wise to inform your patient that this must be completed accurately.

The patient should be advised to complete this section and to follow the instructions provided by the carrier in the dental plan booklet.

The dental office does not complete this section.

Submission of Claim

The patient and subscriber/insured must complete their portions of the claim form in addition to signing the appropriate places. Be sure to put an "X" by the lines to indicate where a signature is expected.

For the standard CDA approved claim form, instruct the patient to fill in the employee/subscriber/insurer parts of the form and submit it as directed in their plan brochure.

Ensure that the patient receives claim forms for any completed services while treatment is in progress. The maximum interval between claim forms should be one month. Many patients will request their forms on a daily or a weekly basis, and this is reasonable to assist in patient reimbursement. Claim forms should be given to the patient.

It is the patient's (or parent's/guardian's) responsibility to forward the claim to his plan administrator. If he procrastinates or does not follow the printed instructions, any problems arising become his responsibility and will not involve the dental office.

Information about purchasing the CDA Approved Standard Dental Claim Form is available from the CDA or your Provincial Dental Association.

Additional Procedures

Important:

It is prudent TO KNOW and to HAVE ON RECORD exactly what is on each claim form, treatment plan form, supplementary information form, expertise statement or any other correspondence between a prepaid dental plan carrier and the dental office. There will be times when it is necessary to refer to data already sent in for a patient.

KEEP A COPY OF EVERYTHING.

APPENDIX I

CDA NINE DIGIT NUMBERING SYSTEM

Over the years, a Nine Digit Numbering System has been developed by CDA, through its Council on Health Care and, more recently, the Third Party Dental Plans Committee. This numbering system has been developed for use in Dental Claim Forms.

The first two digits are allocated to identify the individual provinces, numbered as follows:

Newfoundland	01
Prince Edward Island	02
Nova Scotia	03
New Brunswick	04
Quebec	05
Ontario	06
Manitoba	07
Saskatchewan	08
Alberta	09
British Columbia	10
Northwest Territories	11
Yukon Territories	12

If the dentist is incorporated, 50 should be added to the provincial number - i.e., an incorporated dentist in the province of B.C. would have 60 as the provincial designation.

The next five numbers are allocated at the discretion of the corporate or licensing bodies and usually constitute the dentist's licence number.

The eighth number is used for specialty classification, as follows:

0	General Practitioner
1	Public Health Dentist
2	Endodontist
3	Oral Pathologist
4	Oral Surgeon
5	Orthodontist
6	Pedodontist
7	Periodontist
8	Radiologist
9	Prosthodontist

The ninth number is for member classification, to be assigned by the provincial association.

When a dentist moves to another province, a new number is assigned.

NOTICE TO PATIENTS

The treatment plan I have recommended is what I deem necessary based on my thorough examination and diagnosis. The responsibility of your insurance company is to assist you to pay the cost of dental treatment as limited by your contract, whereas as your dentist **my primary concern is your dental health.** Even though the proposed treatment may be a covered benefit of your insurance plan, the company may base their liability on a less costly compromise treatment. Keep in mind that insurance companies employ dentists and in some cases non-dental personnel to assess their liability. This consultant has not examined you personally. If the benefits assessed by the insurance company are unacceptable to you, I urge you to pursue this matter with the insurance company immediately.



CANADIAN DENTAL ASSOCIATION

L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6

PRESCRIPTION RADIOGRAPHY

A NEW CONCEPT FOR RADIATION PROTECTION IN DENTAL PRACTICE

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ABSTRACT

The continuing increase in both the number of dental films taken and the proportion of the population exposed to dental radiation has created a public perception of indiscriminate usage. Of particular concern is the use of routine or "screening" radiography which has little scientific basis and is not compatible with the current philosophy and published guidelines for the use of diagnostic radiation. The unfavourable public image and the frustration of dealing with it can be readily eliminated by adhering to the principles of the International Commission on Radiological Protection, as expressed in the concept of prescription radiography.

SOMMAIRE

L'incessante augmentation du nombre de radiographies dentaires prises et du pourcentage du public exposé aux radiations a fait naître dans l'esprit de celui-ci l'idée que les dentistes utilisent les radiographies à tort et à travers. On s'inquiète surtout des radiographies de "dépistage" prises de façon routinière, ce qui ne se justifie guère sur le plan scientifique et n'est conforme ni à la philosophie actuelle ni aux directives publiées touchant l'usage des radiographies pour fins de diagnostic. L'idée négative entretenue par le public et les frustrations qui en découlent peuvent être éliminées en suivant les principes de la Commission internationale de protection contre les radiations formulés en rapport avec les radiographies.

INTRODUCTION

The science and art of radiography has been, for many years, an essential part of the practice of dentistry. Dental diagnosis, treatment and disease prevention depend in many instances on the information derived from properly exposed and processed radiographs. Currently, the need to continue efforts to improve radiation hygiene is an issue of high priority for the scientific and health communities. Government regulatory agencies, consumer advocacy groups and the public press have stated views on this subject which have serious implications for the practice of dental radiography. In view of the concerns expressed and the measures proposed, dentistry and medicine are reassessing both the methodology and the philosophy of radiation usage.

The purpose of this article is to review pertinent developments in dental radiography in the post-war decades and to examine the impact of the current philosophy of diagnostic radiation usage on these established practices. In doing so, we will show that the profession has consistently adopted better radiation hygiene methods. We will discuss the current concerns about the health hazards from repeated low-level exposure to x-radiation and evaluate the reasons why dental radiographic practices are identified as a problem, in spite of a relatively minor contribution to total patient exposure. The recommendations of the scientific, regulatory and professional bodies, both national and international, will be summarized.

These recommendations have produced significant changes in dental school curricula and will increasingly alter our traditional concept of dental radiography. Detailed suggestions are presented for the practical application of the contemporary concept of prescription radiography.

DENTAL RADIOGRAPHY – A FOCUS OF CONCERN

Why has the dental profession's use of radiation been one of the main targets for criticism? This attention seems to be disproportionate to our contribution to patient dosage since, out of the total amount estimated for all forms of diagnostic radiation, dentistry accounts for less than 3 per cent.¹ National and international organizations have identified certain features of dental radiation use as items of concern. Before examining these specifically, there are some general facts* which focus attention on the profession:

- 1) Dentists own over 50 per cent of diagnostic x-ray generators.²
- 2) The profit from the use of x-rays is seen by consumer advocate groups to create a vested interest in the use of radiation.
- 3) In the United States, dental radiographs account for 30 per cent of all diagnostic films.³ In 1970 an estimated 278 million intraoral radiographs were made, and by 1980, this number had grown to 400 million.⁴

*The figures used are from the United States but are closely applicable to most Western countries

4) Radiography is the most frequently provided dental service. Over 50 per cent of the population of the United States visit the dentist annually and 80 per cent of these patients have radiographs taken.⁵

Similar data have been reported from Sweden, Great Britain and Japan. In these countries, dramatic increases in the number of dental radiographs have occurred in the last two decades.⁶ In Great Britain, dental radiography has been described as a "growth industry", particularly in reference to the expanded use of pantomography.⁷

In addition to these general facts, some specific practices have been identified which, if they are to be continued, will require proof of patient benefit. These are:

1) The routine exposure of children and adolescents to a set number of radiographs at first visit and then at specific intervals. Most parental and medical concern arises from this practice.

2) Similar surveys for adult patients.

3) The use of multiple intraoral radiographs, resulting in overlapping exposure of tissue.

4) A total reliance on direct-exposure, radiation-intensive emulsions for intraoral films.

5) The use of "administrative" radiographs.

6) The use of uncertified ancillary personnel as radiographic technicians.

7) The lack of a universal inspection in private offices to ensure equipment efficiency.

MINIMIZING PATIENT EXPOSURE IN DIAGNOSTIC RADIOGRAPHY

The Hazards of Low Levels of Ionizing Radiation

Humans have always been exposed to natural radiation. The amount depends on geographical and geological factors such as altitude and mineral content of the local terrain. However, in this, the latter half of the twentieth century, population exposure has doubled, with over 90 per cent of this increase due to the diagnostic use of man-made radiation.⁸ This large increase has logically led to the question of whether there is additional risk from such low-level radiation. It has been known for many years that large doses, i.e. 100 rads or more, cause physical and chemical cellular change which can lead to neoplasia or cell death. Diagnostic radiography generally involves repeated exposures of less than 20 rads of absorbed radiation. While most of the damage produced by this level of radiation is reversed by healing processes, a proportion of the deleterious effects are irreversible and therefore cumulative. The most significant consequences of radiation on cells are muta-

genic and carcinogenic. Currently, more stress is placed on the danger of the carcinogenic effect on individuals, with a lessening of the concern for the hereditary effects of population exposure. The risk of mutation, for example, for a dental radiographic examination is only of the order of 1 per billion.⁹ On the other hand, the probability of the carcinogenic effect is believed to be stochastic, i.e. although the risk is proportional to the dose, there is no known lower limit or threshold. The consequences are severe and independent of the quantity of radiation.¹⁰ It should be clearly understood that risk estimates at low doses are based mostly upon extrapolation and interpretation of data at higher doses on humans and not upon direct proof. There is also a considerable body of evidence on the somatic effects of repeated low level exposure in experimental animal studies. However, until there is proof that these effects *do not occur* in humans, it is prudent to adopt a conservative philosophy.

The Risk/Benefit Concept

There have been enormous advances in the efficiency of radiographic technique since its introduction as a diagnostic method. Under the stimulus of the International Commission on Radiological Protection (I.C.R.P.) and equivalent national organizations, continuous improvements have been made in methods of protecting operating personnel and patients. Subsequent to achieving significant improvements in technical efficiency, efforts were directed to evaluate the productivity of both diagnostic and investigative radiography. The concept of risk vs benefit was developed to achieve a more selective and productive use of radiation. This concept implies that if there is a probability of obtaining information of benefit to the patient, then the presumed inherent risk is acceptable and the procedure can be justified. As a result of application of this principle, most of the mass screening programs have been abandoned and substantial reductions in routine diagnostic use have occurred.¹¹ For example, the only routine investigative radiography currently in use in medicine is mammography for women over 45 years of age, because of the high incidence of breast cancer in this group.¹²

Recommendations of the International Commission on Radiological Protection

This Commission was created in 1928 by the International Congress on Radiology because of growing concern about the biological effects of the use of ionizing radiation. The Congress is composed of scientific delegations from most of the world's

nations and it selects the members of the Commission. The Commission has an official working relationship with other major international health agencies such as the World Health Organization, the International Atomic Energy Agency and the United Nations Scientific Committee on the Effects of Atomic Radiation. Based on the premise that there is no "safe" dose of radiation, the I.C.R.P. issues recommendations which influence the practice of all the professions that use diagnostic radiology. The principles of justification and technical efficiency underlie these recommendations.¹³ In this context, justification means that the physician or dentist, using professional judgement, proposes radiological examination only where information of net benefit to the patient can be anticipated. In the Commission's view, it is particularly important to justify radiography in the management of non-malignant conditions, such as those most often encountered in dental practice, since the most significant risk from exposure to x-radiation is the induction of malignancy. The development of selection criteria is encouraged to improve the decision-making process and thus the efficacy of radiography. The Commission states that the physician should "refrain from making routine requests which are not based upon clinical indications."¹⁴ The application of professional judgement aided by selection criteria should significantly reduce the use of unproductive radiography.

Technical efficiency is the second principle governing the use of diagnostic radiography. According to the Commission, there can be no excuse for examinations carried out with excessive exposure. Efforts should be made to confine the dose to the tissues directly involved in the diagnosis and thus reduce the total volume of tissue irradiated. This is an application of the principle that radiation doses should be kept "As Low As Reasonably Achievable." (ALARA)

In summary, the I.C.R.P. recommends that radiography can contribute maximum patient benefit when clearly indicated and competently performed. Additionally, the Commission observes that if patients were informed of this concept, they would be better able to place their concerns in proper perspective.

THE DEVELOPMENT OF RADIOGRAPHY IN DENTAL PRACTICE

The potential for radiography in dental diagnosis was apparent in the early years after Roentgen's discovery of x-radiation. The significance of intraoral radiography, especially the bitewing film for caries diagnosis, was well-established by the time of the Second World War. In the post-war

years, major improvements in films and generators combined with new concepts in the teaching of diagnosis and radiology led to the expansion of radiography in dental practice. New departments were established to teach the concept of comprehensive examination as a necessary first step to treatment planning and prevention. The use of routine radiographic surveys (the complete mouth survey or C.M.S.) became an integral part of the examination of all new patients. For those patients with signs or symptoms, the radiographic survey was an effective application of diagnostic radiation. However, for some patients the protocol of a routine survey of a pre-determined number of radiographs would in today's terms be described as investigative or screening radiography. One of the stated objectives of survey radiography is the discovery of hidden or occult disease. More recently, the same claim has been made to justify the use of pantomography in a screening role. In medicine, investigative radiography was used in mass screenings for breast cancer, chest films and spinal examinations for workers in heavy industry. It was the era of the annual medical checkup, when it was argued that early disclosure of hidden lesions, i.e. before signs of disease were present, would improve the chances of suc-

cessful treatment and possibly decrease costs.

Achievements in Dose Reduction in Dentistry

During the period of rapid expansion in the diagnostic use of radiation, a parallel effort to improve radiation hygiene was developing. This was based upon an accumulating body of scientific data on the hazards of ionizing radiation. While the consequences of acute radiation exposure were known early in this century, the insidious latent effects of chronic, low-level exposure on personnel working with radiation or radioactive material became evident only after years of use. Acting on this knowledge, the I.C.R.P. developed the concept of maximum permissible dose and barrier protection for radiation workers. Once this problem was resolved, the attention of the scientific community focused on the development of measures to reduce patient exposure during diagnostic radiography. The effects of these efforts on dentistry would be dramatic.

Although dental x-ray tubes of the post-war period were technically advanced even by present standards, radiation usage was inefficient compared with current practice. To illustrate the significance of improvements adopted in the 1960s, we will out-

line the standard technique of that period and describe how relatively few modifications contributed to a remarkable improvement in the efficient use of diagnostic radiation.

The generators were operated at 60 or 65 kVp and 10 mA. The focus-film distance (FFD) was eight inches, with a short plastic cone as the usual aiming device. Filtration, if present, consisted of 0.5 mm of aluminum built into the tube port. The beam diameter at the skin measured four to six inches and the film used would be classed today by the American National Standards Institute as Speed C (e.g. Kodak Radiatized). The entrance skin exposure (ESE) of this technique averaged about 5R per intraoral radiograph. A complete mouth series of 20 films (16 periapicals and four bitewings) would expose a patient to 100R of primary radiation. By today's standards, this is a very significant amount of radiation, even though it represented the best practice of the period.

Major reductions in exposure were achieved by increased filtration, collimation of the beam and the use of faster film. Other modifications of technique such as the use of higher kilovoltages and longer focus-to-film distances with open-ended tubes effected minor but nonetheless useful reduc-

Even After Brushing
With Fluoride,
Teeth Need
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In Listermint.
Here's Clinical
Evidence.



tions. The unfiltered beam from a dental generator contains a proportion of soft x-rays which are absorbed by the patient without contributing to the image. Most of these low-energy photons were removed by the addition of metal filters, resulting in a beam containing a higher proportion of useful rays. This added filtration reduced radiation exposure to patients by 50 per cent. Current regulations require that 1.5 mm of aluminum be present in all dental generators operating at 70 kVp or below; where the units operate above 70 kVp, 2.5 mm of aluminum is required. To reduce the beam diameter to our present mandatory 2.75 inches, collimators (lead washers) were inserted. These effected a further 40-50 per cent reduction in radiation exposure. However, the most significant reduction was achieved by the introduction of Speed D film. This film (e.g. Kodak Ultra-Speed) was approximately four times faster than the Radiatized Film and reduced exposures by 75 per cent. These modifications decreased patient exposure for a 20-film CMS from 100 R to less than 5 R or approximately 200-300 mR per film. An entire CMS can be made today with less radiation than was previously required for a single periapical film. This voluntary achievement should be a source of pride to the profession.

The Validity of Screening Radiography

Subsequent to the achievement of significant improvements in the efficiency of our techniques, the productivity or net benefit to the patient from our routine surveys has been the focus of recent studies on dental radiographic practices. The dental literature over the past 20 years contains many reports on the information yield from the routine use of CMS and/or pantomography. Cumulative results are difficult to evaluate because of variations in the populations studied and the kinds of items that were tabulated. The data from the major studies of the past years are presented in Table I. The results taken from these papers have been condensed and arranged into dental and non-dental categories. Accommodations had to be made for imprecise nomenclature and varying definitions of what constitutes a "pathological" entity. The major findings were impacted teeth, osteitis and retained roots. All other findings were relatively rare. In some studies, the term osteitis was applied to all forms of bone resorption around teeth, including periodontal disease. The incidence of retained roots was 7.8 per cent, with a slightly higher percentage (9.5 per cent) in edentulous mouths.

There was no indication whether these roots were the cause of symptoms or would have required extraction.

Some difficulty in interpretation existed in the findings of 0.77 per cent cysts since they were rarely classified by the authors. Therefore, we are reporting the combined results as dental pathology, although recognizing the fact that a small number were cysts of non-dental origin. The odontogenic benign tumours consisted entirely of odontomes although one "cementoma" was reported. By far, the most common finding relating to the maxillary sinus was the mucous retention cyst. Nonodontogenic benign tumours were reported in 0.05 per cent of the surveys. Of these, most were ossifying fibromas, two were osteomas and there was one central giant cell granuloma. The single malignant tumour was a multiple myeloma. The study which reported this tumour, did not indicate whether the patient had other evidence of the disease.²⁶ Virtually all the foreign bodies were amalgam fragments. Very often the authors of the surveys reported radiolucencies and radiopacities with neither specific diagnosis nor indication whether treatment would be required. We have summarized these and reported them as unspecified radiolucencies and radiopacities.

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doubts. But the accumulation of evidence from independent clinical studies* has become so persuasive, we believe it will overcome your skepticism.

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†neutral pH 0.22 mg/mL of sodium fluoride (100 ppm fluoride ion) 1. Torell, P.; Erickson, Y.: Int'l workshop on IL/dental caries red. (1974) 2. Ripa, L.W. JADA 102:477-481 (1981) 3. Bartlett, J.M.; Torell, P.; Caries Res. 12 Suppl II 38-51 (1978) 4. Driscoll, W.S.; Swango, P.A.; Horowitz, A.M.; Kingman, A. JADA 105:1010-1013 (1982) 5. Kouloulides, T. Data on file Warner-Lambert Canada Inc. 1985.

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TABLE I
Information Yield from
34,421 Radiographic
Surveys¹⁵⁻²⁹

DENTAL FINDINGS	PERCENT PREVALENCE
Impacted teeth	13.3
Osteitis	10.1
Retained roots	7.8
Cysts	.77
Supernumerary teeth	.34
Neoplasia	
Benign	.06
Malignant	.00
NON-DENTAL FINDINGS	
Sinus abnormalities	1.2
Dysplasia	.04
Neoplasia	
Benign	.05
Malignant	.003
OTHER	
Radiolucency + radiopacity (unspecified)	1.2
Calcified stylohyoid ligament	4.9
Foreign bodies	.81

TABLE II
Selection criteria for
asymptomatic patients

Physical Sign or Historical Criterion	Examples of Potential Diagnostic Information Yield
Missing tooth — one or more	Root tips, agenesis, impaction, cyst or neoplasm
Loss of coronal tooth substance attributable to trauma or caries	Proximity to pulp, periapical osteitis, root fracture
Change in tooth translucency or color	Caries, periapical osteitis
Cracks in enamel or restoration	Extent of fracture, recurrent caries
Abnormal mobility	Loss of periodontal bone support, neoplasia
Unexplained change in bony contour	Cyst, dysplasia, neoplasia
True periodontal pocket	Loss of supporting alveolar bone
Unexplained colour change in mucosa	Cyst, haemangioma, giant cell granuloma
Draining sinus	Periapical infection
Malposed tooth	Odontoma, supernumerary
Some malformations of teeth	Dens invaginatus
History of trauma, pain, swelling, difficult extraction, hereditary predisposition	Fracture, osteitis, retained root tips, developmental anomaly

It can be assumed that many of the patients surveyed (Table I) had clinical signs or symptoms which would have prompted an examiner to prescribe one or more radiographs. When this factor is taken into consideration, the percentages of incidentally discovered occult disease disclosed by radiography would be significantly reduced. The chance discovery of serious occult disease such as neoplasia is negligible. Conclusions on the importance of screening films have been based on the percentage of findings rather than on a critical analysis of their clinical significance. As well, in reporting findings there is no discrimination between those conditions which would have been suspected from clinical examination and purely occult or incidental findings. However, more recent studies^{30,31} have purposefully attempted to analyze screening radiography in terms of risk vs. patient benefit i.e. how many of these incidental findings have any bearing on patient health and thus require treatment. Barrett et al.³⁰ found that of 1,000 patients routinely examined by pantomographs, only 12 patients had pathoses that required definitive treatment and none required urgent attention. These studies conclude that screening examinations are unproductive and do not conform to the current philosophy of radiation hygiene.

Current Recommendations of National Agencies and Professional Dental Organizations

Most of the technically advanced countries have official agencies or institutes which analyze, develop and disseminate information and issue recommendations on all aspects of radiation used in the health sciences. In Canada, there is the Radiation Protection Bureau of Health and Welfare Canada and in Britain the National Radiological Protection Board. In the United States, there are the Bureau of Radiological Health (U.S. Department of Health) and the National Council on Radiation Protection (NCRP). In Canada the Radiation Protection Bureau has published Safety Codes which were developed in consultation with the official organizations representing every branch of the Health Sciences. The most recent code for dental radiographic practice (Safety Code-22) makes the following recommendations:³²

1) "the prescription of an x-ray examination should only be based on a clinical evaluation of the patient."

2) "routine or screening examinations in which there is no prior clinical evaluation should not be prescribed . . . and this is especially to be deplored when children are exposed."

National professional associations have promulgated recommendations on radiographic practice based upon the principles developed by the I.C.R.P. The following excerpts are from the recommendations of the Canadian Dental Association.³³

1) "the prescription of an x-ray examination by a licensed dentist should only be based on a clinical examination."

2) "the justification for taking dental radiographs should be determined by a perceived need to obtain specific information which could contribute to a correct diagnosis or prevention rather than utilizing the concept of routine periodic examination with or without having seen the patient beforehand."

The following excerpts are from the recently revised recommendations of the American Dental Association:³⁴

1) "the nature and extent of diagnosis required for patient care, rather than the concept of routine use of x-rays as a part of periodic examination of all patients, constitute the only rational basis for determining the need, type and frequency of radiographic examination."

2) "as each patient is different from the next, so should radiographic examination be individualized for each patient."

3) "decisions regarding the use of radiography should be based on a thorough clinical examination and the medical and dental history of the patient."

Clearly, the statements of these organizations endorse the I.C.R.P. principles of radiation use which is a distinct departure from some of our customary practices. The concept of prescription radiography based upon the findings of clinical examination rather than routine radiography has been introduced into the curriculum of most dental schools. Indeed, in the United States, this is a required condition for accreditation by the Council on Dental Education. Increasingly, texts and articles dealing with radiography and diagnosis emphasize these principles.

PRESCRIPTION RADIOGRAPHY FOR DENTAL PRACTICE

There has been an understandable but quite erroneous impression that the current recommendations for radiation reduction imply an across-the-board reduction in the number of films taken. When this misconception is held, there follows a logical and often vigorously expressed fear that dental practice will be hampered and the quality of service will suffer; and also the fear of professional negligence if screening radiographs are not taken. **There has never been a recommendation to reduce the number of films required to establish a diagnosis and treatment plan for those conditions disclosed by clinical exami-**

nation. Rather, current radiation hygiene recommendations are intended to eliminate radiographs ordered without prior examination or where no clinical indication is disclosed by examination.

The Development and Use of Selection Criteria

The concept of selection criteria has been proposed to facilitate the application of prescription radiography. These criteria are specific clinical and/or history findings which indicate the need for certain types and numbers of radiographs, with the expectation that these will provide information directly related to the solution of diagnostic and treatment problems. The use of such criteria (also called high yield criteria) has been studied extensively in medicine, particularly in hospital practice. They have been shown to significantly reduce overutilization and increase the efficacy of the radiographic method.³⁵ Recently, dental educators have attempted to develop protocols with appropriate selection criteria for use in dentistry.^{36, 37} The American Academy of Dental Radiology has established a Dental X-ray Selection Criteria Panel to develop selection criteria for dental x-ray examination of asymptomatic patients. Continued validation through research will be required.

Selection criteria for symptomatic patients: The use of selection criteria is best illustrated for the patient with a complaint. The classic signs and symptoms of dental or oral disease (pain, swelling, fractures of tooth or bone, caries etc.) are obvious clinical indications for radiography as an aid in diagnosis and management. The number and types of radiographs are determined directly by the problem. Misuse by under-utilization, for example the single periapical, could be a greater concern than over-utilization. In many instances at least two intraoral films are indicated (using different projection angles), supplemented as occasion demands by extraoral films.

Selection criteria for asymptomatic patients: For the patients who are asymptomatic, the application of selection criteria is a substantial departure from our traditional approach. Some of these patients may have physical signs and/or pertinent history data that require further diagnostic evaluation. For these, radiography may be the preferred if not the only method of investigation. On the other hand, many patients have neither symptoms nor physical signs of disease. Caution must be taken in developing and applying selection criteria for this group.

For asymptomatic patients with physical signs and/or pertinent history, selection criteria can be readily identified. In Table II, are listed many of the common clinical and

historical findings for which there is a reasonable expectation that radiographs will disclose information of benefit to the patient. It is recognized that not every sign or history finding will indicate a need for radiographic examination. For example, there are many soft tissue lesions where radiography is most unlikely to provide any useful information.

For asymptomatic patients without physical signs or pertinent history data, we suggest that selection criteria are not appropriate. Until very recently, it has been accepted protocol that even in the absence of clinical indications, some form of routine radiographic examination should be made for these patients. The routine use of radiography, as noted earlier, was considered to be an essential part of the comprehensive oral examination. These "check-up" films were meant to ensure that no hidden or occult disease, especially malignancy, was overlooked. Such films have often been described as baseline or scout films. In our interpretation of the current concept of radiographic practice, no films are indicated for this group of asymptomatic patients.

In spite of approved and published guidelines that radiography should be based upon specific clinical and/or historical criteria, there is evident reluctance by some to apply this principle. At a recent dental conference which reviewed radiographic practices for children, the group at highest risk, a protocol had been suggested which apparently is the antithesis of the recommended guidelines. The following quotation is taken from an article summarizing the results of that conference: "Radiographs may also be made in the absence of any clinically apparent problem . . ."³⁷ The argument used to support the use of routine radiographs is the early detection of conditions such as supernumerary teeth, agenesis of permanent

teeth, fused or geminated teeth and other developmental anomalies. In addition, assessing the dental age and monitoring dental development have been given as appropriate "criteria".

What is the evidence for the efficacy of early and repeated radiography for the child-adolescent patient? Table III shows the combined data from the major studies most frequently used in support of this practice. Evaluation of the data in this table indicates a low yield of serious disease: i.e., those conditions which require either urgent or elective treatment. Many of these patients would exhibit clinical signs indicating a need for radiography. For example, in one study of 70 patients with supernumeraries, over 74 per cent had signs such as delayed eruption, rotation or displacement.⁴³ This significantly reduces the per cent yield of "occult" findings. As well, a great percentage of the conditions found are not treatable upon early disclosure, if at all. None of these studies in Table III reported any disclosure of neoplasia, metabolic disturbances or other significant disease. In the light of these considerations, there is scant justification for initial screening of asymptomatic children without signs or pertinent history. A recent, well-documented review article in the Journal of Dentistry for Children,⁴⁴ supports our conclusion.

In summary, the use of criteria which are not based upon clinical indications subverts the current concept of diagnostic radiography. It seems to be an attempt to support the continued use of screening radiography masquerading as prescription radiography. **The Detection of Dental Caries – A Limited Role for Screening Radiography:** The incidence of dental caries and the severe restrictions on clinical examination of posterior proximal surfaces, are strong arguments for the use of bitewings as a limited form of screening radiography for

TABLE III
Information yield from screening radiography in children

Author	No. of Patients	Age Range	Percent Hypodontia	Percent Supernumeraries	Percent Fusion/Gemination
Clayton, 1956 ³⁸	3,557	3-12	6.0	1.9	0.5
Castaldi, 1966 ³⁹	457	6-9	4.1	3.1	0.2
McKibben, 1971 ⁴⁰	1,500	3-12	5.4	1.5	0.4
Bergstrom, 1977 ⁴¹	2,589	8-9	7.4	1.5	0
Buenaviaje, 1984 ⁴²	2,439	2-12	3.7	0.5	0.5
Totals and Averages	10,542	2-12	5.3	1.7	0.3

the new patient.⁴⁵ The absence of proximal contact, which permits direct clinical inspection and the availability of recent radiographs would be exceptions to this application. The validity of routinely repeating bitewings at intervals (e.g. every six months) has not been established.¹² Recently, a protocol was proposed which advocates a rational approach for the use of these radiographs.⁴⁶ Fig. 1 illustrates such a scheme. After the clinical examination, including bitewing radiographs, patients are assigned to either a high or low risk group. The time intervals suggested are guidelines only and should be modified by clinical judgement. They are not to be construed as recommendations for clinical examination intervals, which are determined as well on an individual basis. Although the use of such a protocol has not been validated by research, it seems to be a pragmatic approach based upon knowledge of the pathogenesis and epidemiology of dental caries.

Non-diagnostic Radiography

Radiography related to Treatment: During the development of treatment plans or in the course of treatment, the application of radiography may be essential. Some examples of these situations follow:

- 1) Fixed or removable prosthetics — Even in the absence of signs or symptoms, prior knowledge of root number, length, shape and the level of bone support is critical to proper execution of these procedures.
- 2) Endodontics — this form of treatment requires radiographs during and after the procedure.
- 3) Orthodontics — Radiographs are necessary for pre-treatment analysis and to monitor treatment progress.
- 4) Surgical — Radiographic information is critical in planning the procedure to avoid surgical misadventure and for postoperative evaluation.

Administrative radiographs: By definition, these are radiographs taken for

purposes other than the diagnostic and treatment needs of the patient.⁴⁷ Some examples are:

- 1) Treatment verification films required by insurance carriers, teaching clinics or licensing bodies.
- 2) Radiographs ordered in teaching programmes solely to meet numerical clinical requirements or to demonstrate competence. Also, the retaking of films for technical or aesthetic reasons, even though the image detail may be sufficient for the intended diagnostic use.
- 3) Screening radiographs to assess patient acceptability for teaching clinics.
- 4) A requirement of a specific number of films used in licensing and specialty examination.

In the present context, there is great difficulty in finding any justification for these practices.

CONCLUSION

While addressing the continuing and legitimate concerns about diagnostic radiation exposure, it is important that our present practices be judged in terms of the accepted techniques of the recent past. From this perspective, it should be evident that modern radiographic practice has reached a very high level of efficiency. The potential for further improving efficiency through the use of faster film, rectangular collimation, xeroradiography and rare earth screen/film systems, should continue to be explored. However, in spite of such opportunities for technical improvements, further major reductions in both medicine and dentistry can likely be achieved only by reducing overutilization through the application of the I.C.R.P. principle of justification.

The public perception that dental radiography is a problem in radiation hygiene has its basis in the belief that we do not use sufficient discretion in the application of this potentially harmful diagnostic aid. The widespread understanding by dentists that routine or screening radiographs serve an

important public health function has little if any scientific basis. The customary defence of dismissing such exposures as insignificant and therefore "safe" is unquestionably contrary to the current philosophy of radiation usage. If radiographs are taken only where specific clinical and/or history findings indicate a diagnostic need, most, if not all the criticism would be defused.

Our professional organizations have endorsed the philosophy of the I.C.R.P. and have published recommendations which conform to currently accepted principles of diagnostic radiation hygiene. Confidence in our practices can be restored without jeopardy or cost by simply following these recommendations. We hope this review will encourage dentists to assess their radiographic practices and to make the appropriate adjustments. If we do not respond constructively, then it is becoming increasingly apparent that radiation usage will be directed not by the dentist but by governmental regulatory bodies.

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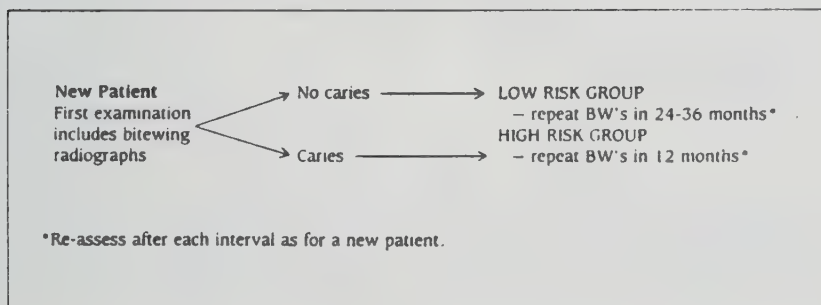
Dr. Reid is a professor and chairman, Division of Oral Radiology, The University of Western Ontario.

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FIGURE 1

Screening radiography for dental caries



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COUNCIL ON CONSTITUTION BY-LAWS

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

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 Dr. E.F. Allison, Calgary - Executive Liaison

1. Council Meetings

Since the 1986 Annual Meeting of the Board, no meetings of the Council have taken place. All items requiring action were handled through a Conference Call on January 27, 1987 or through written correspondence.

ITEMS REQUIRING BOARD ACTION

At the 1986 Annual Meeting of the Canadian Dental Association, notices of motion were directed to the Council on Constitution and By-Laws concerning the Canadian Dental Association Mission Statement and also with respect to Article XVII (sections).

During the Conference Call, certain discrepancies were also identified within the existing Constitution and Bylaws.

It is the recommendation of the Council that the Board attend to these "housekeeping" items in accordance with Article XXVII, Section 2.

2. Notice of Motion - CDA Mission Statement

As directed at the 1986 Interim Meeting of the Board, the CDA Mission Statement has been further reviewed and revised. Comment of corporate members was requested, received and considered in the revision of the statement.

RESOLVED

86.63 THAT the appended CDA Mission Statement be approved.

COUNCIL ON CONSTITUTION BY-LAWS

2.

RESOLVED

- 86.64 THAT the Council on Constitution and By-Laws be directed to prepare the necessary by-law amendment.

Following a review of this Mission Statement, the following was recommended.

APPENDIX I

RESOLVED:

- 87.48 THAT Article IV - Objects and Purposes be approved as amended.

ADOPTED

3. Notice of Motion - Article XVII

APPENDIX II

RESOLVED:

- 87.49 THAT Article XVII be approved as amended.

ADOPTED

4. The following items require consideration of the Board. These items have been identified within the current Constitution and By-Law as being inconsistent and should be amended to bring the document up to date.

(a) Article V - Membership

In reviewing the current Constitution and By-Laws, Article V - "Membership" still refers to eight classes of membership - including Associateship.

APPENDIX III

RESOLVED:

- 87.50 THAT Article V be approved as amended.

ADOPTED

(b) Article XVI - Council and Committees

Section 2 (b) refers to Article XVI, Section 2 (d) which is non-existent. A review has indicated that this discrepancy has existed since 1977. Your Council is of the opinion that the appropriate reference should be Article X - Section 7.

APPENDIX IV

RESOLVED:

87.51 **THAT Article XVI - Councils and Committees,
Section 2 (b) be approved as amended.**

ADOPTED

(c) Article XVI - Terms of Reference

Article XVI Section 4 (b) - Terms of Reference - Council on Dental Materials and Devices - item (x), the CDRF Awards is now recommended on a biennial basis.

APPENDIX V

RESOLVED:

87.52 **THAT Article XVI - Section 4 (b) (x) be approved as
amended.**

ADOPTED

- (d) Within the Constitution and By-Laws, the terminology "Chairman" and "Chairperson" are both utilized. To be consistent, your Council recommends that a motion be considered to amend the Constitution and By-Laws to sub-substitute the terminology "Chairperson" wherever "Chairman" appears.

RESOLVED:

87.53 **THAT the expression "Chairman" be substituted by
"Chairperson" throughout the CDA Constitution
and By-Laws.**

ADOPTED

-
- (e) At the 1986 Annual Meeting of the Board of Governors of the Canadian Dental Association, Resolution 86.60 dealt with the restructuring of the CDSPI Board of Directors. In adopting this motion, the Board approved a mechanism by which the Canadian Dental Association would appoint two voting directors to the Board of the Canadian Dental Service Plans Inc.

The adoption of this motion does not appear to be in harmony with Article XVI, Section 4 (h).

Your Council awaits direction from the Board on this item.

APPENDIX VI

DIRECTION: As a result of the adoption by the Board of Governors of the resolution 86.60 dealing with the restructuring of the CDSPI Board of Directors, the Council on Constitution and By-Laws is directed to make the appropriate by-laws amendment.

ITEMS FOR INFORMATION NOT REQUIRING BOARD ACTION

1. Council received correspondence from the Executive Council respecting certain items within the Constitution and By-Laws. Response to these questions were forwarded to Executive Council for their consideration.
2. The Council acknowledges with sincere appreciation the efforts of Mrs. Sandra Deziel.

Respectfully submitted,

George H. Peacock, D.D.S.
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Constitution and By-Laws with appreciation.

CURRENT

ARTICLE IV

OBJECTS AND PURPOSES

The objectives and purposes of the Association shall be as follows:

- (a) to cultivate and promote the art and science of dentistry, and all its collateral branches, and to protect and maintain the honour and interests of the dental profession;
- (b) to conduct, direct, encourage, support or provide for exhaustive dental and oral research;
- (c) to elevate and sustain the professional character and education of dentists;
- (d) to promote mutual improvement, social intercourse, and good-will among the members of the profession;
- (e) to enlighten and direct public opinion in relation to oral hygiene, dental prophylaxis, oral health and advanced scientific dental service;
- (f) to disseminate knowledge of dentistry and dental discoveries;
- (g) to have cognizance of and safeguard the common interests of the dental profession;
- (h) to publish dental journals, reports and treatises;
- (i) to promote the delivery of high quality comprehensive dental (oral) health care service to all residents of Canada;
- (j) to do all further or other lawful things and acts as are incidental or conducive to the attainment of the above objects.

PROPOSED

ARTICLE IV

SECTION 1: MISSION STATEMENT

The Canadian Dental Association serves the dental profession - and through the profession the Canadian public - as the authoritative national voice and resource for dentists.

In cooperation with the provincial dental associations and affiliated organizations, the Canadian Dental Association offers services, in both official languages, intended to support and advise all areas of dentistry and to represent, protect, promote and develop the interests of the dentist as ethical practitioner, professional, educator, student, researcher, business person, citizen and individual.

The Canadian Dental Association recognizes a particular responsibility to contribute to the development of national positions and standards related to dentistry, dental education, dental research, dental equipment, dental materials and dental personnel.

The Canadian Dental Association is dedicated to the principle that all Canadians should have the best oral health care it is possible to provide; it actively seeks input from and dialogue with governments, consumers and all those interested in dentistry to enable it to serve more effectively both its members and the Canadian public.

SECTION 2: OBJECTS AND PURPOSES

- (a) to cultivate and promote the art and science of dentistry, and all its collateral branches, and to protect and maintain the honour and interests of the dental profession;
- (b) to conduct, direct, encourage, support or provide for exhaustive dental and oral research;
- (c) to elevate and sustain the professional character and education of dentists;
- (d) to promote mutual improvement, social intercourse, and good-will among the members of the profession;
- (e) to enlighten and direct public opinion in relation to oral hygiene, dental prophylaxis, oral health and advanced scientific dental service;
- (f) to disseminate knowledge of dentistry and dental discoveries;

APPENDIX I

PROPOSED (Cont'd)

- 2 -

- (g) to have cognizance of and safeguard the common interests of the dental profession;
- (h) to publish dental journals, reports and treatises;
- (i) to promote the delivery of high quality comprehensive dental (oral) health care service to all residents of Canada;
- (j) to do all further or other lawful things and acts as are incidental or conducive to the attainment of the above objects.

APPENDIX II

CURRENT

ARTICLE XVII

SECTIONS

Sections of the Association shall be the national organizations of the specialties recognized by the Association and which have applied for and have been admitted to Section status by the Board of Governors.

(a) The Sections of the Association are:

SPECIALTY	ASSOCIATION/SOCIETY
Endodontics	Cdn Academy of Endodontics
Oral & Maxillofacial Surgery	Cdn Assoc. of Oral & Maxillofacial Surgeons
Oral Pathology	Cdn Academy of Oral Pathology
Oral Radiology	Cdn Academy of Oral Radiology
Orthodontics	Cdn Assoc. of Orthodontics
Paedodontics	Cdn Academy of Paedodontics
Peridontology	Cdn Academy of Peridontology
Prosthodontics	The Assoc. of Prosthodontics of Canada
Public Health Dentistry	Cdn Society of Public Health Dentists

APPENDIX II

PROPOSED

ARTICLE XVII

SECTIONS

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(a) The Sections of the Association are:

SPECIALTY	ASSOCIATION/SOCIETY
Endodontics	Cdn Academy of Endodontics
Oral & Maxillofacial Surgery	Cdn Assoc. of Oral & Maxillofacial Surgeons
Oral Pathology	Cdn Academy of Oral Pathology
Oral Radiology	Cdn Academy of Oral Radiology
Orthodontics	Cdn Assoc. of Orthodontics
Paedodontics	Cdn Academy of Pediatric Dentistry
Peridontology	Cdn Academy of Peridontology
Prosthodontics	The Assoc. of Prosthodontics of Canada
Public Health Dentistry	Cdn Society of Public Health Dentists

CURRENT

ARTICLE V

MEMBERSHIP

There shall be eight (8) classes of members in the Association: Corporate (voting), Active, Affiliate, Honorary, Life, Associate, Student and Supporting Members.

Section 1 - Corporate Members (Voting Members)

- (a) Corporate members shall consist of the provincial statutory dental associations and the Canadian Forces Dental Services.
- (b) The following shall be eligible for Corporate membership on payment of the annual fee:
 - The College of Dental Surgeons of British Columbia
 - The Alberta Dental Association
 - The College of Dental Surgeons of Saskatchewan
 - The Manitoba Dental Association
 - The Ontario Dental Association
 - L'Association des chirurgiens-dentistes du Québec
 - The New Brunswick Dental Society
 - The Nova Scotia Dental Association
 - The Dental Association of Prince Edward Island
 - The Newfoundland Dental Association
 - The Canadian Forces Dental Services
- (c) Continuance of membership by a Corporate member shall be contingent upon payment of an annual fee established by Article XIX.
- (d) Corporate membership shall terminate and be deemed to be assigned to the Board of Governors of the Association if a Corporate member fails to pay its annual fee when payable.
- (e) No corporate member shall withdraw from membership except upon written notice to the President of the Association who will present the notice to the next annual meeting of the Board of Governors.
- (f) A Corporate member may withdraw membership one year after notice of withdrawal of membership has been received.
- (g) Corporate membership of a withdrawing member shall be deemed to be assigned to the Board of Governors of the Association.
- (h) The Executive Director will advise the Corporate members of any notice of withdrawal of membership, or of any failure to make payment of the annual fee when payable, within thirty days of receipt of such notice by the President or within thirty days of the expiry of the payment date of the annual fee, or at the next annual meeting of the Board of Governors, whichever date shall occur first.

PROPOSED

ARTICLE V

MEMBERSHIP

There shall be seven (7) classes of members in the Association: Corporate (voting), Active, Affiliate, Honorary, Life, Student and Supporting Members.

Section 1 - Corporate Members (Voting Members)

- (a) Corporate members shall consist of the provincial statutory dental associations and the Canadian Forces Dental Services.
- (b) The following shall be eligible for Corporate membership on payment of the annual fee:

The College of Dental Surgeons of British Columbia
The Alberta Dental Association
The College of Dental Surgeons of Saskatchewan
The Manitoba Dental Association
The Ontario Dental Association
L'Association des chirurgiens-dentistes du Québec
The New Brunswick Dental Society
The Nova Scotia Dental Association
The Dental Association of Prince Edward Island
The Newfoundland Dental Association
The Canadian Forces Dental Services

- (c) Continuance of membership by a Corporate member shall be contingent upon payment of an annual fee established by Article XIX.
- (d) Corporate membership shall terminate and be deemed to be assigned to the Board of Governors of the Association if a Corporate member fails to pay its annual fee when payable.
- (e) No corporate member shall withdraw from membership except upon written notice to the President of the Association who will present the notice to the next annual meeting of the Board of Governors.
- (f) A Corporate member may withdraw membership one year after notice of withdrawal of membership has been received.
- (g) Corporate membership of a withdrawing member shall be deemed to be assigned to the Board of Governors of the Association.
- (h) The Executive Director will advise the Corporate members of any notice of withdrawal of membership, or of any failure to make payment of the annual fee when payable, within thirty days of receipt of such notice by the President or within thirty days of the expiry of the payment date of the annual fee, or at the next annual meeting of the Board of Governors, whichever date shall occur first.

(Current)

Section 2 - Active Members

Licensed dentists who are members in good standing of the Corporate Member in a Province of Canada shall become Active Members on recommendation of the Corporate Member and on payment of the appropriate annual fee. A specialist licensed in the Province of Quebec and therefore a member of the Order of Dentists of Quebec can be considered an Active Member of the Canadian Dental Association upon payment of the annual dues.

Section 3 - Affiliate Members

Dentists in good standing, licensed to practise dentistry in a Province or Territory of Canada, but who are not members of the Corporate Member for that Province or Territory shall become Affiliate Members on payment of the appropriate annual fee.

Section 4 - Honorary Members

Persons who shall have rendered valuable service to the Association, and such other persons as may be determined by the Executive Council shall, with their own consent and upon election as such by the Executive Council, be Honorary Members of the Association.

Section 5 - Life Members

Any dentist who has been a member of the Canadian Dental Association in good standing for a minimum of forty (40) years regardless of age of applicant will, with the approval of the Executive Council, become a Life Member of the Association.

Section 6 - Student Members

Any undergraduate student in an accredited dental school in Canada, or any Canadian citizen who is a student in a CDA recognized Faculty of Dentistry outside Canada, who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

Section 7 - Supporting Members

Any dentist in good standing who is no longer licensed to practise in Canada, or who is fully retired from dental practice, teaching or administration or who presents special mitigating circumstances, or any other person having an interest in the well-being of the Association and who does not otherwise qualify, shall be eligible to apply for admission as a Supporting Member and shall become a Supporting Member upon approval by the Executive Council and payment of the appropriate fee.

(Proposed)

Section 2 - Active Members

Licensed dentists who are members in good standing of the Corporate Member in a Province of Canada shall become Active Members on recommendation of the Corporate Member and on payment of the appropriate annual fee. A specialist licensed in the Province of Quebec and therefore a member of the Order of Dentists of Quebec can be considered an Active Member of the Canadian Dental Association upon payment of the annual dues.

Section 3 - Affiliate Members

Dentists in good standing, licensed to practise dentistry in a Province or Territory of Canada, but who are not members of the Corporate Member for that Province or Territory shall become Affiliate Members on payment of the appropriate annual fee.

Section 4 - Honorary Members

Persons who shall have rendered valuable service to the Association, and such other persons as may be determined by the Executive Council shall, with their own consent and upon election as such by the Executive Council, be Honorary Members of the Association.

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Any dentist who has been a member of the Canadian Dental Association in good standing for a minimum of forty (40) years regardless of age of applicant will, with the approval of the Executive Council, become a Life Member of the Association.

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Any undergraduate student in an accredited dental school in Canada, or any Canadian citizen who is a student in a CDA recognized Faculty of Dentistry outside Canada, who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

Section 7 - Supporting Members

Any dentist in good standing who is no longer licensed to practise in Canada, or who is fully retired from dental practice, teaching or administration or who presents special mitigating circumstances, or any other person having an interest in the well-being of the Association and who does not otherwise qualify, shall be eligible to apply for admission as a Supporting Member and shall become a Supporting Member upon approval by the Executive Council and payment of the appropriate fee.

CURRENT

ARTICLE XVI

COUNCILS AND COMMITTEES

Section 2 - Nomination and Election

- (a) Nominees for membership on councils shall be placed in nomination at the annual meeting of the Board of Governors.
- (b) All council members shall be elected or appointed by the Board of Governors at the annual meeting pursuant to Article XVI, Section 2 (d) of these by-laws.
- (c) The Council on Nominations, Awards and Trusts shall be nominated and elected by the Board of Governors at the annual meeting pursuant to Article X, Section 6 of these by-laws.

PROPOSED

ARTICLE XVI

COUNCILS AND COMMITTEES

Section 1 - Nomination and Election

- (a) Nominees for membership on councils shall be placed in nomination at the annual meeting of the Board of Governors.
- (b) All council members shall be elected or appointed by the Board of Governors at the annual meeting pursuant to Article X, Section 7 of these bylaws.
- (c) The Council on Nominations, Awards and Trusts shall be nominated and elected by the Board of Governors at the annual meeting pursuant to Article X, Section 6 of these bylaws.

CURRENT

(b) Council on Dental Materials and Devices

The Council on Dental Materials and Devices shall consist of eight (8) persons who shall be appointed annually by the Board of Governors. It shall be the duty of the Dental Materials and Devices Council:

- (i) to act in an advisory and consultative capacity for evaluation of those materials and devices employed in the practice of dentistry and in the maintenance of oral health.
- (ii) to develop Canadian standards for dental materials and devices in liaison with the Canadian Standards Association and other standards writing organizations and through the Standards Council of Canada with the International Organization for Standardization (ISO).
- (iii) to encourage a programme for testing, evaluation, acceptance and certification in Canada.
- (iv) to call upon consultants for assistance and advice, where appropriate, with the approval of Executive Council.
- (v) to review and comment where necessary on advertising and/or demonstration of any non-pharmacological aspects of materials and devices employed in dental procedures falling within the jurisdiction of this Council.
- (vi) to report on a regular basis to the Executive Council and to the Board of Governors and to provide an annual budget for approval.
- (vii) to communicate to the Membership through the CDA journal and by other means, such information as it considers to be of interest and importance to the dental practitioners.
- (viii) to maintain a liaison with the American Dental Association Council on Dental Materials.
- (ix) to maintain an active liaison with the Health Protection Branch, Department of National Health and Welfare and other agencies concerned with dental materials and devices.
- (x) to recommend annually to the Executive Council, the recipient of the C.D.R.F. award.

PROPOSED

(b) Council on Dental Materials and Devices

The Council on Dental Materials and Devices shall consist of eight (8) persons who shall be appointed annually by the Board of Governors. It shall be the duty of the Dental Materials and Devices Council:

- (i) to act in an advisory and consultative capacity for evaluation of those materials and devices employed in the practice of dentistry and in the maintenance of oral health.
- (ii) to develop Canadian standards for dental materials and devices in liaison with the Canadian Standards Association and other standards writing organizations and through the Standards Council of Canada with the International Organization for Standardization (ISO).
- (iii) to encourage a programme for testing, evaluation, acceptance and certification in Canada.
- (iv) to call upon consultants for assistance and advice, where appropriate, with the approval of Executive Council.
- (v) to review and comment where necessary on advertising and/or demonstration of any non-pharmacological aspects of materials and devices employed in dental procedures falling within the jurisdiction of this Council.
- (vi) to report on a regular basis to the Executive Council and to the Board of Governors and to provide an annual budget for approval.
- (vii) to communicate to the Membership through the CDA journal and by other means, such information as it considers to be of interest and importance to the dental practitioners.
- (viii) to maintain a liaison with the American Dental Association Council on Dental Materials.
- (ix) to maintain an active liaison with the Health Protection Branch, Department of National Health and Welfare and other agencies concerned with dental materials and devices.
- (x) to recommend biennially to the Executive Council, the recipient of the C.D.R.F. award.

CURRENT

(h) Council on Insurance and Investment

The Canadian Dental Association has delegated to the Canadian Dental Service Plans Inc. the functions of the Council on Insurance and Investment as a result of an administrative agreement between the two organizations. This agreement is to be reviewed annually by the Board of Governors of the Canadian Dental Association and Canadian Dental Service Plans Inc.

The Canadian Dental Association shall appoint two directors, provided that one such director shall be a resident of the Province of Ontario and the other shall be a resident of the Province of Quebec, providing this is done in consultation with Ontario and Quebec.

It shall be the duty of the Council on Insurance and Investment:

- (i) to recommend to the Executive Council the kinds of insurance and terms of coverage which are desirable for the membership to carry and which can be advantageously purveyed to the membership on a group basis;
- (ii) to survey the insurance market to determine the costs, terms and conditions of available coverage;
- (iii) to negotiate and recommend for approval to the Executive Council the costs, terms and conditions of contracts with the chosen carriers;
- (iv) to periodically review the insurance contracts in order to determine the suitability of contracts and the possibility of improved terms and of more economic terms and to assess the proposals of competing carriers;
- (v) to recommend to the Executive Council the time and manner of distribution of surplus or reserve funds;
- (vi) to advise on and review Association-sponsored pension and retirement savings plans;
- (vii) to report annually all actions to the Board of Governors.

APPENDIX VI

MOTION APPROVED

ANNUAL MEETING OF THE BOARD OF GOVERNORS

AUGUST 22-23, 1986

The Canadian Dental Association will appoint two voting directors to the Board of Canadian Dental Service Plans Inc. One of these directors shall be appointed at large by the Canadian Dental Association. The other voting director shall be appointed from its Executive Council; this appointee will serve as Executive Liaison to the Council on Insurance and Investment.

COUNCIL ON EDUCATION & ACCREDITATION

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. A. Schwartz, Chairman, Winnipeg
Dr. G. Beagrie, Vancouver
Dr. M. Boyd, Vancouver
Dr. G. Burgman, Kirkland Lake
Dr. H. Dick, Edmonton
Dr. B. Graham, Halifax
Dr. M. Jahjah, Montreal
Dr. A. LaBounty, Vancouver
Ms. K. MacDonald, Halifax
Dr. E. McIntyre, Edmonton
Mrs. M. Paquin, Vancouver
Dr. K. Pownall, Toronto
Miss J. Robarts, Welland
Dr. G. Thompson, Edmonton
Dr. R. Thordarson, Vancouver
Dr. I. Vogan, Halifax
Mr. B. Barr, Winnipeg

Dr. J. Christie, Executive Liaison, Halifax

1. Council Meetings

Although the Council on Education and Accreditation has not met since the annual meeting of the Board of Governors last August, Council directed that national competency profiles for Dental Assisting and Dental Hygiene be revised and presented to the Interim Meeting of the Board of Governors for approval.

2. Items Requiring Board Action

APPENDIX A

Members of the Board will recall that earlier drafts of these competency profiles were presented for information and that approval was not sought because there were concerns about the wording of several sections. The Council on Education and Accreditation approved the competency profiles in principle in June 1986 and directed that they be presented to the Interim Meeting of the Board following their further revision to remove specific points of concern. Early in January, 1987, a special review committee chaired by Mr. Brian Henderson met to carry out this task. Dentists on the review committee included Dr. B. Dolansky of Ontario,

COUNCIL ON EDUCATION & ACCREDITATION

Items Requiring Board Action (cont'd.)

Dr. J.-P. Lamarche of Quebec, Dr. K. Skinner of Manitoba, Dr. D. MacIntosh of Nova Scotia and Dr. A. Schwartz (as Chairman of the Council on Education and Accreditation). The representatives from Dental Hygiene were Dianne Gallagher and Carole Worobey, who are respectively President and Executive Director of the Canadian Dental Hygienists Association. No special representation was present from the Canadian Dental Assistants Association as concerns expressed about the earlier draft documents were related to the Dental Hygiene Competency Profile. Nevertheless, the review committee made some parallel revisions in the Level I (Extra-oral) Dental Assisting Competency Profile, without changing its substance. It was decided that the Level II (Intra-oral) Dental Assisting Competency profile also required further revision but that the special review committee was not prepared to accomplish this. Consequently, the Level II (Intra-oral) Dental Assisting Competency Profile will be further revised in consultation with representatives of Dental Assisting and presented for approval to a future meeting of the CDA Board of Governors.

I believe that these competency profiles are presented in a form which reflects the principle of dental supervision as expressed in legislation in each province and also recognizes the distinct and valuable contributions made by Dental Assistants and Dental Hygienists. The profiles are also based upon a core of duties and responsibilities for Dental Assistants and Dental Hygienists which is common across all provinces. These competency profiles will be important and useful in a variety of contexts, as explained in the introductory sections accompanying each document. I respectfully request your support for and approval of each of these competency profiles.

RESOLVED:

- 87.54 THAT the Level I (Extra-oral) Dental Assisting Competency Profile be approved.**

ADOPTED

COUNCIL ON EDUCATION & ACCREDITATION

- 3 -

Items Requiring Board Action (cont'd.)

RESOLVED:

- 87.55 THAT the Dental Hygiene Competency Profile be approved.

WITHDRAWN

RESOLVED:

- 87.56 THAT the Executive Council, in coordination with the provincial associations, develop a strategy for CDA to address the developments in Ontario which may have ramifications in the balance of the country concerning changing legislation for dental hygienists.

ADOPTED

Respectfully submitted,

Dr. Arthur Schwartz, Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Education and Accreditation with appreciation.

LEVEL 1 DENTAL ASSISTING COMPETENCY PROFILE

CONTENTS (in alphabetical order)

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LEVEL I DENTAL ASSISTING COMPETENCY PROFILE

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INTRODUCTION TO LEVEL I DENTAL ASSISTING COMPETENCY PROFILE

Purpose

The CDA Accreditation process reviews educational programs for Dental Assistants against national standards established through the CDA Council on Education and Accreditation. These national standards specify that educational programs shall be assessed in terms of their potential ability to meet their own **declared educational objectives**. Such a starting point for the accreditation process grants full recognition to the specific expertise of educators who may employ a variety of educational approaches in meeting their declared objectives.

One consequence of this policy is the need for the CDA Accreditation process to define a set of **MINIMUM BASIC OBJECTIVES** for educational programs for Dental Assistants. Without specific minimum objectives, CDA could be placed in the position of accrediting a program purporting to prepare assistants when the declared goals of the educational program were far too limited to warrant recognition of the program's graduates as assistants. Conversely, it is important to identify limits in terms of what duties are recognized by the national accreditation process.

This document, **LEVEL I DENTAL ASSISTING COMPETENCY PROFILE**, presents an official, detailed list of minimum skills or abilities to be expected of any graduate of any nationally accredited Level I educational program for assistants. (Level I programs are those preparing graduates limited to extra-oral duties; Level II programs involve intra-oral duties. A further competency profile is being prepared to provide detail on intra-oral skills assessed in the accreditation of Level II programs for Dental Assistants.)

Programs applying for Accreditation must include the specific terminal objectives for the appropriate level(s) within their own declared objectives. Educational programs are granted a great degree of flexibility in **how** they meet these objectives, but they must demonstrate both that they **aim** to meet them and that they **can** do so.

(i)

Assumptions Concerning Dental Supervision:

The LEVEL 1 DENTAL ASSISTING COMPETENCY PROFILE rests upon the basic assumption that **all duties listed within the profile are subject to requirements for supervision by a licenced practicing dentist as defined in each province.**

How The Competency Profile Was Established:

The CDA Council on Education and Accreditation recognized the need to introduce national competency profiles in support of the national accreditation process. A special working group was established in the fall of 1985 to collect information on provincial competency profiles and other resources. The Canadian Dental Association and the Canadian Dental Assistants Association both contributed funds to support the project and a dental auxiliary education consultant, Wendy Halowski, was engaged. The consultant was directed by the working group to review resources and prepare a discussion paper outlining elements of a competency profile for dental hygienists and dental assistants that reflected those duties that each is permitted to perform in every province. Because of wide provincial variation in duties permitted to required of dental assistants, the LEVEL 1 DENTAL ASSISTING COMPETENCY PROFILE is limited to extra-oral duties; a separate competency profile is being developed to describe those extra-oral duties which are assessed during the accreditation of a Level II program for Dental Assistants. The Level I Competency Profile was reviewed and revised during several meetings of the working group. Initial drafts were also circulated to licencing authorities, educators and organizations representing assistants across Canada and comments were invited and considered. The CDA Council on education and Accreditation approved the document in principle, subject to final editing, in June 1986. A special meeting was held Janaury, 1987 to assist in the final editing of the document.

SECTION I: CONDUCT APPROPRIATE TO A PROFESSIONAL SETTING

As a team member in a professional practice, the dental assistant contributes to the creation of a professional atmosphere. A professional attitude and ethics are fostered through examination and clarification of values, attitudes, beliefs, mission and vision. These are demonstrated through behaviour and interactions with patients, colleagues, other members of the dental team and the public. Since professional behaviour is difficult to precisely define, some indicators of professional behaviour have been described.

I-I COMPETENCY: Apply Communication Skills

CONDITIONS:

CRITERIA:

1. Demonstrate interviewing techniques.
2. Demonstrate listening skills.
3. Demonstrate speaking skills.
4. Interpret nonverbal behaviour.
5. Develop helping, supporting relationships.
6. Demonstrate decision-making skills.
7. Demonstrate problem-solving skills.
8. Demonstrate conflict-management skills.
9. Handle incoming and outgoing calls on the telephone.

I-2 COMPETENCY: Demonstrate Job-finding Skills

CONDITIONS:

CRITERIA:

1. Prepare a resume.
2. Locate employment opportunities.
3. Write a letter of application for a prospective position.
4. Participate in an interview with a prospective employer.
5. Write an employment agreement.

I-3 COMPETENCY: Demonstrate Ethics Appropriate to a Professional Setting

CONDITIONS:

CRITERIA:

1. Perform delegated functions within the regulations of the governing body.
2. Demonstrate a responsible professional relationship with patients.
3. Demonstrate a professional relationship with colleagues.
4. Explain peer review and its process in the province.
5. Perform self-evaluation and improve where necessary.
6. Maintain standards in patient care for quality assurance.
7. Address ethical dilemmas.
8. Support dental assisting professional organizations.
9. Research current issues in dental assisting.

SECTION II: DENTAL HEALTH EDUCATION

As a member of the dental team and an oral health educator, it is the responsibility of the dental assistant to be involved in providing dental health education to patients and groups in the community. To do this effectively, knowledge and understanding of some basic principles of instruction and learning are essential. These principles can then be applied to each teaching situation and adapted to suit the needs of the individuals involved.

II-1 COMPETENCY: Apply Principles of Instruction and Learning

CONDITIONS: When working with individuals or groups, providing instruction in dental health.

CRITERIA:

1. Establish learning environment.
2. Progress at rate of learner(s).
3. Use small, ordered steps during instruction.
4. Provide immediate feedback to learner(s).
5. Obtain feedback from learner(s).
6. Encourage active participation by learner(s).
7. Provide positive reinforcement.
8. Assist learner(s) in setting goals for desired change.
9. Use scientifically accurate information, visual aids and resources.

II-2 COMPETENCY: Instruct Patients in Oral Hygiene Care

CONDITIONS: Delegated patients of varying age ranges and varying special needs.

CRITERIA:

1. Identify presence of plaque and plaque-related problems.
2. Select oral physiotherapy aids and audiovisual materials.
3. Demonstrate effective use of oral physiotherapy aids.
4. Review patient progress.
5. Provide factual information related to patient's needs and concerns.
6. Apply principles of instruction and learning.
7. Apply communication skills.
8. Record recommendations, patient progress and modifications.
9. Encourage patient's self-care.

II-3 COMPETENCY: Instruct Patients in Diet Related to Oral Conditions

CONDITIONS: Delegated patients who have a need related to oral conditions present and have expressed an interest in their diet.

CRITERIA:

1. Determine dietary changes needed.
2. Plan individualized dietary recommendations.
3. Present recommendations to patient.
4. Review patient progress.
5. Apply principles of instruction and learning.
6. Apply communication skills.
7. Record recommendations, patient progress and modifications.

II-4 COMPETENCY: Participate in Community Dental Health Programs

CONDITIONS: Delegated a segment of the community with a specific dental health need and the opportunity to consult with appropriate resources.

CRITERIA:

1. Identify dental health programs or projects in community.
2. Provide information about oral health to groups and/or individuals.
3. Apply principles of instruction and learning.
4. Identify health resources available in community.

SECTION III: PATIENT CARE PROCEDURES

Patient care describes the extraoral clinical skills needed by the chairside dental assistant in the delivery of routine dental services under the supervision or direction of the dentist. In this role, the dental assistant is responsible for those procedures which do not require the skill and knowledge of the dentist. In assisting the dentist, the dental assistant must make judgements and decisions regarding her areas of expertise and thus must have the necessary related knowledge to perform these procedures independently. The dental assistant must maintain the chain of asepsis when assisting in clinical practice.

III-1 COMPETENCY: ADMINISTER EMERGENCY CARE

CONDITIONS: Given situations involving an emergency in the clinical practice setting.

CRITERIA:

1. Maintain office emergency kit.
2. Prepare for potential emergency situations including rehearsal of emergency responses.
3. Recognize signs and symptoms of emergency situation.
4. Summon aid.
5. Administer basic first aid, when required.
6. Administer CPR, when required.
7. Monitor vital signs.
8. Operate oxygen administration equipment.
9. Transfer care to attending dentist or medical personnel.
10. Assist attending personnel in administration of emergency care.
11. Record description of emergency care.

III-2 COMPETENCY: Assist with Diagnostic Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in collecting diagnostic data.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - health histories
 - oral examinations
 - study model impressions
 - diagnostic tests
 - radiographs
3. Complete medical laboratory test forms when indicated.
4. Mix and prepare dental materials used in diagnostic procedures according to manufacturer's directions.
5. Record and chart data.

III-3 COMPETENCY: Assist with Endodontic Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing endodontic procedures.

- CRITERIA:
1. Apply clinical support procedures when indicated.
 2. Assist with taking endodontic radiographs.
 3. Prepare and transfer armamentarium for:
 - examination
 - emergency treatment
 - canal instrumentation
 - canal obturation
 - endodontic surgery
 4. Mix and prepare materials used in endodontics according to manufacturer's directions.

III-4 COMPETENCY: Assist with Operative Dentistry Procedures

CONDITIONS: Working in clinical situations, assisting the dentist in performing operative dental procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - cavity preparation
 - bases and liners
 - amalgam restorations
 - tooth-coloured restorations
 - temporary restorations
 - extracoronar restorations
 - pin placement
3. Mix and prepare dental materials used in operative dental procedures according to manufacturer's directions.

III-5 COMPETENCY: Assist with Oral Surgery Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing oral surgery procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - examination
 - extractions
 - surgical procedures
 - suture placement and removal
3. Assist in treatment of pre- and post-operative infections
4. Assist in preparation of cytological smears and biopsy specimens.
5. Mix and prepare materials used in oral surgery according to manufacturer's directions.

III-6 COMPETENCY: Assist with Orthodontic Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing orthodontic procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - examination
 - placement of bands/brackets and arch wires
 - adjustment of bands and arch wires
 - removal of bands
 - construction of fixed and removable appliances
3. Mix and prepare dental materials used in orthodontics according to manufacturer's directions.

III-7 COMPETENCY: Assist with Pediatric Dentistry Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing Pediatric Dentistry procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Assist with patient management when indicated.
3. Prepare and transfer armamentarium for:
 - examination
 - operative procedures
 - stainless steel crown procedures
 - preventive procedures
 - pulpal therapy
 - space maintenance
 - surgical procedures
4. Mix and prepare materials used in Pediatric Dentistry according to manufacturer's directions.

III-8 COMPETENCY: Assist with Periodontic Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing periodontic procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - examination
 - scaling, root smoothing, and curettage
 - occlusal equilibration
 - periodontal surgery
 - maintenace care
3. Mix and prepare materials used in periodontics according to manufacturer's directions.

III-9 COMPETENCY: Assist with Prosthodontic Procedures

CONDITIONS: Working in a clinical situation, assisting the dentist in performing fixed and removable prosthodontic procedures.

CRITERIA:

1. Apply clinical support procedures when indicated.
2. Prepare and transfer armamentarium for:
 - examination
 - preparation for fixed prosthodontics
 - impressions for fixed prosthodontics
 - temporization for fixed prosthodontics
 - cementation for fixed prosthodontics
 - construction of removable partial denture
 - construction of complete denture
3. Mix and prepare materials used in prosthodontics according to manufacturer's directions.
4. Complete laboratory prescription forms when indicated.

III-10 COMPETENCY: Assist with Pain Control Administration

CONDITIONS: Working in a clinical situation, assisting the dentist in the administration of local anaesthetic agents.

CRITERIA:

1. Apply clinical support procedures when indicated.

Local Anaesthetic Agents

1. Identify area to be anaesthetized.
2. Prepare and transfer armamentarium for:
 - application of topical anaesthetic agents.
 - administration of local anaesthetic agents.
3. Observe patient for signs of possible complications.
4. Dispose of used syringe.

Sedation

1. Prepare and transfer armamentarium for:
 - Intravenous injection
 - administration of general anesthesia*
 - administration of relative analgesia*
2. Observe patient for signs of possible complications.
3. Dispose of used syringe.
4. Record information in chart.

*Instruction in the principles of these procedures is required. Clinical practice is desirable but not required.

III-11 COMPETENCY: Assist with Rubber Dam Application

CONDITIONS: Working in a clinical situation, assisting the dentist in rubber dam application and removal.

CRITERIA:

1. Determine area of application.
2. Select clamp.
3. Prepare the rubber dam.
4. Transfer instruments and supplies during application.
5. Hold dam to expose teeth.
6. Transfer instruments and supplies during removal.

III-12 COMPETENCY: Clean Removable Appliances

CONDITIONS: Delegated patients with removable appliances with adherent deposits.

CRITERIA:

1. Place appliance in ultrasonic cleaner, when indicated.
2. Remove soft deposits.
3. Inspect appliance to ensure all deposits removed.

III-13 COMPETENCY: Managing Patients with Varying Types of Special Needs

CONDITIONS: Working in a clinical situation, assisting the dentist with patients with varying types of special needs.

- CRITERIA:**
1. Identify patients requiring modification to treatment plan and approach.
 2. Carry out necessary modifications to equipment and delivery of care.
 3. Implement oral health education based upon individualized needs.

III-14 COMPETENCY: Obtain Preliminary Health History

CONDITIONS: Delegated patients with varying medical and dental conditions which affect dental treatment.

CRITERIA:

1. Assist patient in answering health history form, when indicated.
2. Question non-normal conditions reported.
3. Complete health history form accurately.
4. Identify health problems and conditions requiring modification of treatment.
5. Review findings with dentist/instructor.
6. Obtain further information when indicated.
7. Ensure that health history is signed and dated by patient.
8. Update health history form prior to treatment.

III-15 COMPETENCY: Obtain Vital Signs

CONDITIONS: Delegated patients with varying age ranges and varying medical histories.

CRITERIA:

1. Record blood pressure.
2. Record pulse.
3. Record respiration.
4. Record temperature.
5. Record height and weight.
6. Record vital signs.

SECTION IV: CLINICAL SUPPORT PROCEDURES

Many procedures are necessary to support and facilitate the delivery of patient care. These procedures are an essential part of patient care and if not performed, the quality of patient care is affected. Some are performed for each patient appointment while others are performed when indicated.

IV-1 COMPETENCY: Apply Principles of Asepsis

CONDITIONS: Working in clinical situations, when providing patient care.

CRITERIA:

1. Sanitize dental equipment and operatory.
2. Disinfect dental equipment and operatory.
3. Use correct handwashing techniques.
4. Use disposable supplies where appropriate.
5. Prepare instruments and supplies for sterilization.
6. Sterilize instruments and supplies.
7. Store and transfer instruments and supplies in sterile manner.
8. Recognize and correct breaks in chain of asepsis.
9. Monitor sterilization techniques.
10. Protect patient and self from cross-contamination.

IV-2 COMPETENCY: Apply Principles of Instrumentation

CONDITIONS: Working in clinical situations and using appropriate instruments.

CRITERIA:

1. Determine use of instrument.
2. Determine working end of instrument.
3. Establish appropriate grasp.
4. Establish and use fulcrum.
5. Adapt and/or angulate instrument.
6. Activate stroke.
7. Avoid trauma to hard and soft tissue.

IV-3 COMPETENCY: Assemble Armamentarium

CONDITIONS: Working in clinical situations, prior to providing patient care.

CRITERIA:

1. Select instruments, equipment and supplies needed for procedure(s).
2. Arrange instruments in order of use.
3. Organize equipment and supplies close to operator in working zone.
4. Maintain principles of asepsis.

IV-4 COMPETENCY: Maintain Dental Operatory and Equipment

CONDITIONS: Working in clinical situations, prior to providing patient care.

CRITERIA:

1. Operate basic dental equipment in operatory.
2. Clean and oil equipment according to manufacturer's directions.
3. Organize equipment and supplies according to daily routine.
4. Restock supplies as needed.
5. Clean operatory between patients.
6. Use materials and supplies so that unnecessary waste is avoided.

IV-5 COMPETENCY: Maintain Patient's Comfort

CONDITIONS: Working in clinical situations when providing patient care and with appropriate consultation when required.

CRITERIA:

1. Greet patient.
2. Escort patient to operatory.
3. Seat patient in chair.
4. Store patient's belongings.
5. Prepare patient for procedures to be performed.
6. Explain procedures to be performed.
7. Answer patient's questions.
8. Respond to patient's concerns.
9. Provide post-procedure instructions.
10. Dismiss patient at conclusion of appointment.

IV-6 COMPETENCY: Maintain Operating Field

CONDITIONS: Working in clinical situations, when providing patient care.

CRITERIA:

1. Illuminate operating field with dental light.
2. Retract soft tissue structures.
3. Evacuate oral cavity with high-and low-volume suction.
4. Dry operating field.
5. Irrigate operating field with triplex syringe.
6. Avoid obstructing view and accessibility to operating field.
7. Avoid inducing pain and/or trauma to hard and soft tissues.

IV-7 COMPETENCY: Maintain Dental Records

CONDITIONS: Working in clinical situations when providing patient care.

CRITERIA:

1. Chart and/or record examination data.
2. Chart and/or record services rendered.
3. Record pharmacologic therapy administered and/or prescribed.
4. Record pertinent information regarding patient.
5. Use accepted symbols, terminology and abbreviations.
6. Meet legal requirements for documentation.

IV-8 COMPETENCY: Position Patient and Self

CONDITIONS: Working in clinical situations when performing delegated functions.

CRITERIA:

1. Pre-position chair for client reception.
2. Position patient in chair applying principles of body mechanics and support.
3. Position self as assistant in chair applying principles of body mechanics and support.
4. Position patient for dismissal.
5. Respect patient's personal space requirements.

IV-8 COMPETENCY: Process Dental Radiographs

CONDITIONS: Delegated exposed dental radiographs, including a full-mouth series.

CRITERIA:

1. Prepare darkroom.
2. Remove film from packets.
3. Develop radiographs free of artifacts manually.
4. Operate automatic processing unit, if available.
5. Replenish or change processing solutions when required.
6. Clean and maintain darkroom supplies and equipment.
7. Mount films in correct window in film mount.
8. Label radiographs.

IV-10 COMPETENCY: Sharpen Instruments

CONDITIONS: Working in clinical situations, prior to providing patient care and while providing patient care.

CRITERIA:

1. Identify cutting edges and contour.
2. Prepare stone for sharpening.
3. Stabilize instrument or stone.
4. Apply instrument or stone at correct angle.
5. Activate instrument or stone.
6. Sharpen cutting edge(s).
7. Test for sharpness.
8. Maintain undersurface of instrument, when indicated.
9. Maintain original design of blade.

IV-11 COMPETENCY: Transfer Armamentarium

CONDITIONS: Working in clinical situations, while providing patient care.

CRITERIA:

1. Pass and retrieve armamentarium in transfer zone safely and efficiently.

Operator

2. Use appropriate signal to initiate transfer.
3. Position instrument or supplies for transfer.
4. Receive new instrument or supplies.

Assistant

2. Select instrument for transfer as requested by operator.
3. Hold instrument to be delivered.
4. Retrieve discarded instrument from operator's hand.
5. Place new instrument in operator's hand.
6. Modify principles of transfer when indicated.
7. Transfer dental materials and supplies when indicated.

SECTION V: PRACTICE MANAGEMENT PROCEDURES

As a member of the dental team, the dental assistant must be able to perform basic procedures which are routinely performed in the business office. The office procedures included are those which most directly affect the dental assistant in the delivery of dental care.

V-1 COMPETENCY: Control Appointments

CONDITIONS: Working in the business office of a dental clinic or practice setting.

- CRITERIA:
1. Outline the appointment book.
 2. Sequence appointments according to treatment plan.
 3. Integrate appointments with other team members.
 4. Enter patient information in appointment book.
 5. Confirm appointment time with patient.
 6. Adjust schedule to accommodate changes.
 7. Prepare a daily schedule for the dental office.

V-2 COMPETENCY: Control Patient Accounts

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Explain office policies regarding fee collection.
2. Maintain daily log of charges made and money received using a pegboard system.
3. Complete account ledger cards.
4. Process dental claim forms.
5. Issue receipts.
6. Maintain system for monitoring patients' accounts.

V-3 COMPETENCY: Handle Written Communications

CONDITIONS: Delegated different types of routine correspondence used in a dental office.

CRITERIA:

1. Prepare business letters for mailing.
2. Handle incoming and outgoing mail.
3. Prepare intra- and inter-office communication.

V-4 COMPETENCY: Maintain Business Area

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Operate basic equipment in dental business area.
2. Organize equipment and supplies according to daily routine.
3. Clean business area as needed.
4. Use materials so that unnecessary waste is avoided.

V-5 COMPETENCY: Maintain File System

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Establish a filing system for office information.
2. Establish a filing system for patient records.
3. File records and information according to system established.

V-6 COMPETENCY: Manage Financial Records

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Complete bank deposit slip.
2. Reconcile bank statements.
3. Record petty cash.
4. Record daily and monthly financial information.

V-7 COMPETENCY: Maintain Inventory System

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Organize master list of instruments and supplies.
2. Maintain inventory control records.
3. Order instruments and supplies.
4. Establish reorder point

V-8 COMPETENCY: Manage Recall System

CONDITIONS: Working in the business office of a dental clinic or practice setting.

CRITERIA:

1. Establish a recall system.
2. Record pertinent information regarding recall appointment
3. Contact patients who require appointment.
4. Schedule recall appointment.
5. Modify recall system as required.

SECTION VI: LABORATORY PROCEDURES

As a member of the dental team, it is necessary that the dental assistant be able to perform basic procedures commonly done in a dental laboratory. The number of laboratory procedures has been limited to those related to the patient care and preventive procedures performed by the dental assistant.

VI-1 COMPETENCY: Fabricate Custom Acrylic Trays

CONDITIONS: Working in a dental laboratory setting, with study casts and materials.

- CRITERIA:
1. Sketch desired tray on models.
 2. Adapt spacer to cast.
 3. Prepare stops, when indicated.
 4. Mix and prepare acrylic material.
 5. Adapt material to cast.
 6. Attach handle securely.
 7. Smooth edges and surface.

VI-2 COMPETENCY: Fabricate Mouthguards

CONDITIONS: Working in a dental laboratory setting, with study casts marked with trim line and materials.

CRITERIA:

1. Apply plastic to cast using vacuum technique.
2. Remove plastic from cast.
3. Trim mouthguard to fit trim line.
4. Polish mouthguard.
5. Instruct patient in care and use of mouthguard.

V-3 COMPETENCY: Maintain Dental Laboratory

CONDITIONS: Working in a dental laboratory with equipment and supplies.

CRITERIA:

1. Operate basic equipment in laboratory.
2. Clean and maintain equipment according to manufacturer's directions.
3. Organize equipment and supplies according to daily routine.
4. Restock supplies as needed.
5. Clean laboratory after each use.
6. Use supplies and materials so that unnecessary waste is avoided.
7. Employ principles of infection control.

VI-4 COMPETENCY: Process Study Casts

CONDITIONS: In a dental laboratory, with maxillary and mandibular study model impressions.

CRITERIA:

1. Prepare impressions for pouring.
2. Mix gypsum product according to manufacturer's directions.
3. Pour stone into impressions minimizing voids.
4. Use vibrator when indicated.
5. Create base for impression.
6. Separate model from impression.
7. Prepare model for trimming.
8. Trim maxillary and mandibular models.
9. Label models.

References

For a list of reference employed during the preparation of the national competency profiles for dental auxiliaries, please see pages 52 and 53, Dental Hygiene Competency Profile.

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. J. H. Gryfe, Chairman, Toronto
Dr. C. Foster, Winnipeg
Dr. J. Hardie, Ottawa
Dr. J. V. Legault, Montreal
Dr. E. L. MacInnis, Halifax
Dr. W. S. Walter, Vancouver

Dr. E. F. Allison, Executive Liaison, Edmonton

Items for Information - Not Requiring Board Action

1. CDA Membership on CCHA Board

There have been meetings between Dr. Gryfe and Mr. Henderson representing the CDA and Dr. Jennifer Jackman the Acting Executive Director of the Canadian Council on Hospital Accreditation. Dr. Gryfe and Mr. Henderson with Dr. Normand DaSylva of the Canadian Medical Association and Dr. Gryfe and Mr. Henderson with Mr. Jean-Claude Martin of the Canadian Hospital Association. In each of these informal face-to-face meetings the potential role of the CDA in the CCHA has been discussed frankly and openly and from these discussions it has been surmised that the Canadian Hospital Association would support a bid from the CDA as long as it did not interfere with the Canadian Hospital Association's attempts to restructure the board of the CCHA. As well there seems to have been some mutual understanding arrived at between the Canadian Medical Association and the Canadian Dental Association and this has been substantiated by a letter from the President-elect of the CMA to our President, Dr. Robertson. At present attempts are being made to contact Jeannette Rogers of the Canadian Nursing Association to have a meeting of a similar nature with her and Dr. Gryfe and Mr. Henderson to discuss the Canadian Nursing Association's views of the forthcoming application for CDA membership on the CCHA Board.

2. A letter has been sent to Dr. Bernard Pery the Chairman of the Canadian Council on Hospital Accreditation formally making application for admission to the Board of CCHA and at the same time offering to fulfill the requirements of that application bid at the convenience of the CCHA.

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

3. In summation it appears that the CDA's bid for membership in the CCHA will most likely get a favourable albeit reasonably stormy hearing when the other members of the CCHA hear the criteria we wish to substantiate our admission bid with. It is unlikely, however, to be acted upon until the first half of 1988 as the CCHA must first hire a new Executive Director to replace Dr. Fulvio Limongelli who has recently resigned. Having filled this position the CCHA will then have to assess and deal with their own internal problems specifically related to the current structure of their Board which is unacceptable for some of their present members.

4. Document entitled "Procedures for Oral Care of Chronic Care Patients - A Document for Health Care Workers"

This document which is being prepared jointly by the Council on Hospital and Institutional Services on behalf of the CDA and the Canadian Dental Hygienists Association is in its final draft form. It will be reviewed at the June meeting of the Council and sent forward to the Board at their September meeting. This document of course, in its final form will be Part II of the Guidelines For Chronic Care Maintenance, Part I of which was passed by the Board as the Standards for Chronic Care Maintenance in 1985.

5. Review of Survey Forms

It had been hoped that at the January meeting of the Council on Hospital & Institutional Services a review and rewriting of all of the documents pertinent to the surveys of hospital and institutional services would be undertaken. Because of the cancellation of this Council meeting this task has not as yet been started. Because of the magnitude of this job it is highly unlikely that it will be completed in June of 1987. It is hoped that prior to the June 1987 Council meeting Dr. Gryfe and Mr. Henderson will attempt to at least start to review and restructure these documents.

6. A Protocol for Treatment of Special Patients

A protocol for treatment of special patients (i.e. those patients who may have physical, medical, mental or emotional handicaps that require institutional dental treatment) will be developed. Once again this was a

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

6. A Protocol for Treatment of Special Patients (Cont'd)

project that was to have been started at the January meeting of the Council and there is some doubt that time will allow this protocol to be initiated at the June meeting. In light of the magnitude of this project I would expect that it would be ongoing for perhaps three or four years before a set of documents is completed and accepted for national distribution.

7. Survey Reports

There are a multitude of survey reports to be reviewed regarding hospitals surveys in Toronto, Ontario and London, Ontario as well as Ottawa and possibly Montreal and Halifax. Additionally, there are status reports to review from hospitals in London, Ontario and St. John's, Newfoundland. Because of the mandate of the Council these reports will be reviewed at the June meeting and their results presented to the Board in September.

8. Program - Federal Correctional Services

A possible participation program between the Federal Correctional Services and the CDA will be pursued through Dr. Gary McDonald, dentistry's representative on the Health Committee of the Federal Correctional Services. Early indications lead us to believe that the Federal Correctional Services Ministry may be interested in a trial project that would initially require survey of a dental service in a federal correctional institution and once having acquired appropriate accreditation to introduce either an externship or an internship in that dental facility. As of the time of this memorandum there have been early discussions only and this will not likely be initiated until 1988 at the earliest.

9. The activities of the Council on Hospital & Institutional Services have unfortunately been forestalled by the cancellation of the January 1987 meeting but it is apparent that the significant amount of work which is in

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

9. (Cont'd)

its final stages should be ready for the Board meeting in September 1987 for consideration. The above report is a summation of the work in progress with the Council on Hospital & Institutional Services.

Respectfully submitted,

J.H. Gryfe, D.D.S.
Chairman,
Council on Hospital & Institutional
Services.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Hospital and Institutional Services with appreciation.

COUNCIL ON INFORMATION SERVICES

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Council Members: Dr. Y. Kamachi, Chairman
 Dr. R. Howaniec, B.C.
 Dr. W.T. Koltek, Manitoba
 Dr. G. Lafrenière, Québec
 Dr. P. O'Brien, Nfld.

Executive Liaison: Dr. K. Roach, Ontario

1. Council Meetings

Council has met twice since the last Board, on September 19, 1986 and on January 23, 1987. Mr. Mark Sarner was a guest at both meetings.

Items Requiring Board Action

2. CDA Pamphlet Program

APPENDIX I

In September 1986, Council reviewed CDA's current pamphlet program in conjunction with a Council requested proposal from Manifest Communications. The Manifest proposal suggested revising CDA's current public education program to include the following three components:

- fact sheets on topics in demand
- a consumer-oriented booklet series
- a poster information series

At that time, Council felt that most of the current pamphlets were out of date and the profession's utilization of these materials was relatively low. Consequently, it was suggested that the current series be eliminated and the following motion was brought before the October 1986 Executive Council.

At the Executive Council meeting, this motion was tabled and Council was requested to provide financial analyses and plans to improve the existing program.

COUNCIL ON INFORMATION SERVICES

RESOLVED:

87.57 THAT the Council on Information Services recommend that the current pamphlet program be discontinued at the earliest possible date and that it be replaced by the proposed three-component Patient/Public Information Program;

and

THAT a viable financial plan for the implementation of the Patient/Public Information Program be investigated.

ADOPTED

At the January 1987 meeting, Council reviewed pamphlet sales in 1986 and noted that 3/4 of a million pamphlets had been sold netting CDA a gross profit of \$38,731.42.

APPENDIX II

Nevertheless, Council felt that certain pamphlets were dated and required revision, updating or discarding. Other pamphlets were selling and should continue to be marketed at least for the present time, by CDA at a profit. Eventually they too should be updated and either retained as pamphlets or converted into fact sheets.

Council suggested that for now, the following pamphlets be retained, the price structure be reviewed and updated when necessary, and that these pamphlets be marketed aggressively to the profession:

Eating Properly For Better Dental Health
Dangerous in Bed
Do You Have Periodontal Disease?
Do You Smoke? Have Your Mouth Checked?
Do It Yourself Oral Hygiene
Dental X-Rays Show Hidden Problems

It was suggested that the certain pamphlets from the current series be updated and redeveloped into a fact sheet format. The following pamphlets would be analysed with this intent:

TMJ Disorder
Save that Tooth
Protect that Mouth
Do You Need Complete Dentures?
Facts About Fluoridation
Those Important Baby Teeth

COUNCIL ON INFORMATION SERVICES

The pamphlet "Choosing a Career in Dentistry" would be retained on a limited basis and the remaining pamphlets would be reviewed and a decision made on whether to update or discontinue them.

Similar changes would be made to the French language pamphlets.

Council feels that the pamphlet program should be diversified to meet different needs and updated to be made more current. An upgrading of the current program and the conversion of certain pamphlets into fact sheets would accomplish this objective and would make the program more cost effective. In addition, fact sheets would encourage greater dentist/patient interaction.

Council members felt that they required some flexibility in delineating which pamphlets should be updated but remain as pamphlets, and which ones should be made into fact sheets or discarded, particularly in light of the success of the CDA/Oral-B Brochure. To date, 250,000 copies of the CDA/Oral-B brochure entitled "What Every Adult Should Know About Dental Health" have been sold at 100% profit to CDA. Staff is investigating costs for reprinting this brochure.

The development of new fact sheets, posters and pamphlets could be funded by current pamphlet and fact sheet sales, and/or corporate sponsorship.

To date, ten fact sheets have been developed as part of Dental Health Month Programming. They are as follows:

- Tips for Tooth Troubles
- Gum Disease: Why Your Teeth Need Support
- Growing Up: How Your Dental Needs Change
- Managing a Sweet Tooth
- Advice for Parents
- Changing Your Dental Habits
- Don't Wait Till It Hurts
- How to Talk to Your Dentist
- How to Choose a Dentist
- Facts About Dental Health

These fact sheets will be made available to the profession during Dental Health Month. They will be sold in pad form and the current member, non-member price is \$5.00/pad or \$6.50/pad respectively.

It also is recommended that all new pamphlets, fact sheets and public education materials carry the Good For Life identity.

COUNCIL ON INFORMATION SERVICES

3. DAP Seminars

APPENDIX III

An integral part of the DAP's member relations component is to inform the profession on how to better execute in-office dental awareness programming. One method of accomplishing this objective is through the availability of DAP Seminars across the country.

In the fall of 1986, provincial associations were approached about the prospect of joint CDA/provincial DAP Seminars for the entire dental health care team. At that time, it was stated that CDA would develop a budget for this activity. Provincial associations and/or local societies would market these seminars to their membership, and costs would be recoverable to CDA for the initiation, development and implementation of the seminars. Any additional costs such as those for meeting room rental, refreshments, meals, would be dealt with by the provincial association, local society and/or individual delegate. A tentative budget is attached.

These seminars will be presented by Manifest Communications on a consulting basis. Long term plans include training CDA staff to carry on this project.

Initially these seminars will not be available in French due to limited manpower. There exists the possibility of translating written materials into French and investigating a joint venture between the CDA and ODQ.

RESOLVED:

87.58 THAT the DAP Seminar Program be approved for implementation and marketing to the dental health team.

ADOPTED

It is noted that the seminar will be available to all members of the dental care team - dentist, auxiliaries and office personnel.

Items Not Requiring Board Action

4. CDA/Oral-B Pamphlet

As mentioned previously, the profession has responded overwhelmingly to the joint CDA/Oral-B Brochure. All 250,000 pamphlets have been sold in a two month period. Oral-B was the sole sponsor of this pamphlet and provided CDA with 250,000 overruns to market to the profession. This entire supply has been sold at a 100% profit to CDA. Costs for additional reprints of this pamphlet will be borne by CDA.

COUNCIL ON INFORMATION SERVICES

The success of this endeavour indicates that:

1. The profession needs and responds to new and current patient education information.
2. A joint CDA/corporate sponsored publication is acceptable to the profession if presented and marketed appropriately.
3. CDA has the potential for a successful and greatly expanded public information program.

5. Dental Health Month 1987

1987 Dental Health Month programming focuses on making the "Good For Life Pledge". The purpose of this theme is to get Canadians to make a personal commitment to dental health. Resources which have been developed to support this concept include the pledge poster, the pledge button, a planning kit that provides guidelines for organizing community pledge programs and a motivation sticker. In addition, Good For Life resources are available to provincial associations and community planners. These include a new radio spot, the CDA/Oral-B Brochure on "What Every Adult Should Know About Dental Health", copies of the 1985 and 1986 National Dental Health Check-Ups and the ten fact sheets.

For the first time, the DHM order form was mailed directly to all CDA Members in early February. It is anticipated that there will be a positive response from the profession as a result of this direct mailing.

1987 DHM programming highlights include:

- publication of the third National Dental Health Check-Up in Chatelaine magazine with a distribution of over 1.1 million English and 300,000 French copies to reach over 6 million Canadians. Colgate-Palmolive is once again the sole sponsor of this supplement and negotiations are currently underway to mail a supply of these supplements to each CDA member.
- a direct mailing (via CDA's Communiqué) to all CDA Members of DHM materials (poster, button, decal and supplement) in March in addition to the fourth DAP Report.
- the CDA poster contest for children in kindergarten to grade 7.
- an April 2 reception in Ottawa to launch DHM'87. It is anticipated that key representatives from Health and Welfare, other government departments, health care associations and major dental corporations will meet with CDA Board members and "take the pledge".

COUNCIL ON INFORMATION SERVICES

- a new CDA public service radio spot entitled "Bob's Teeth". It is hoped that this catchy radio spot will attract attention from the media and the public.
- an aggressive pre-DHM media and public relations campaign planned around interviews, pledge events, the radio spot, press releases and media kits.

6. Media Relations

Media coverage of dentistry continues to escalate. Newspaper coverage expanded from 400 articles in June 1985 to 1800 in June 1986 to 3300 in January 1987. The stinger ads continue to appear in newspapers across the country and more and more major magazines are featuring dental related articles. It is hoped that DHM programming will yield even greater coverage in 1987.

7. Provincial Relations

Corporate bodies have been kept informed of DAP/DHM activities through direct mailings and a fall visitation. Memos have been sent to Chief Executive Officers and DHM Chairman as programs develop. In addition, representatives of Manifest Communications met with each provincial association to discuss DHM'87 programming, the pledge concept, a DAP Seminar Series, media relations, etc.

8. Member Relations

Direct communication to the membership remains an integral part of the DAP. Regular articles on the DAP appear in each issue of the CDA Journal. The CDA Communiqué also contains regular DAP information. In addition, a quarterly DAP Report is published and sent directly to members. The third DAP Report was published in October 1986 on educating and motivating adults. A fourth DAP Report is due in March 1987. A copy of the 1987 check-up and other DHM materials will be sent directly to members in March with the CDA Communiqué.

9. Targeted Programming

A number of targeted programs have been developed and continue to be initiated under the auspice of sponsorship dollars. Key programs include:

- Colgate-Palmolive's sole sponsorship of the third National Dental Health Checkup in Chatelaine at a cost of approximately \$325,000.

COUNCIL ON INFORMATION SERVICES

- Oral-B's exclusive sponsorship of the adult oriented booklet "What Every Adult Should Know About Dental Health" and the sale by CDA of 250,000 overruns as part of our pamphlet program.
- a successful targeted seniors program for City of Toronto residents to educate seniors on the importance of good dental health. The City of Toronto paid over \$20,000 for the development of materials which will be used for the next 4-5 years.
- a CFDE grant of \$10,000 to develop a generic program kit model for communities across Canada based on the Toronto Seniors Program.

Discussions continue with corporations for sponsorship of a recall kit and other DAP initiatives. In addition, the DAP is investigating ways to increase the involvement of hygienists in programming activities across the country.

10. Leverage

To date CDA has obtained approximately \$1.35 million in leverage from corporations and outside agencies supporting the "Good For Life" initiative, the most recent sponsorship being Colgate's support of the 3rd "Checkup" and CFDE's grant for development of a seniors kit. (This figure does not include the current \$500,000 ODA campaign which bears Good For Life logo)

11. Research

In previous years, research has been undertaken in the following areas:

- a 1985 survey of health educators to measure the need for dental health education materials
- the Gallup National Omnibus Poll to measure public perceptions of dental health
- a readership survey of the May 1986 issue of Chatelaine magazine containing the second "Checkup".

New initiatives in this area involve:

- a CDA/Provincial syndicated poll which is being planned for May 1987. Environics Research will undertake research to again measure public attitudes to dental health and dental awareness

COUNCIL ON INFORMATION SERVICES

- an application to Health and Welfare for grant monies to undertake a comprehensive evaluation of the DAP with the following objectives:
 - (1) to assess the impact of the DAP on designated objectives
 - (2) to develop an evaluation process which can guide the formulation of a general operation model for preventive oral health promotion.

Utilizing data from the 1985 Omnibus Survey and combining it with the planned May 1987 Environics Survey, the CDA will conduct a final survey in 1989, (hopefully sponsored by Health and Welfare) to establish a longitudinal database to measure the effectiveness of the DAP over a four year period.

Dr. Stephen Kline, an Associate Professor at York University has been designated as the principle investigator and \$84,050 is being requested from Health and Welfare.

This initiative parallels the current government's commitment to health promotion and supports Dr. Peter Glynn's (Assistant Deputy Minister, Health and Welfare Canada) encouragement of CDA's initiative.

To date, the application has been acknowledged but a response is not expected until July 1987.

12. ODA Public Education Campaign

Council congratulates the Ontario Dental Association on the initiation of its public education campaign and the development of a booklet on how to be a better dental consumer. The booklet is an excellent consumer guide, and a groundbreaking initiative by the ODA.

Council looks forward to learning of the prospects of extending the Ontario initiative on a national basis and notes the use of the Good For Life logo on all ODA public education materials.

COUNCIL ON INFORMATION SERVICES

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13. Budget/Finances 1986

APPENDIX IV

Unaudited revenue and expenditure figures for 1986 reveal that revenues from DAP and DHM total \$276,720 while expenses in both categories are \$415,318 and \$69,090 respectively. Administrative costs were slightly under budget at \$21,714. It should be noted that all DAP revenues and a large portion of DHM revenues are recoverable costs from sponsors.

Respectfully submitted,

Y. Kamachi, D.D.S.
Chairman,
Council on Information Services

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Information Services with appreciation.

The Board of Governors commends the Chairman, Dr. Kamachi, and the members of the Council on Information Services for their achievement, particularly concerning the Public Awareness Program.

APPENDIX I



CDA'S PAMPHLET PROGRAM RE-THOUGHT

A Proposal

Prepared for

**Council On Information Services
Canadian Dental Association**

Prepared by

**Manifest Communications Inc.
172 John Street
Toronto, Ontario**

(416) 593-7017

"Dental Health - Good for
Life" is a public
information and
awareness program of the
Canadian Dental
Association.



CDA'S PAMPHLET PROGRAM RE-THOUGHT

An Introduction

On June 6, 1986, Council On Information Services (CIS) asked Manifest to take a hard look at CDA's pamphlet program and to come up with recommendations on how it might be revamped and revitalized. This paper presents an analysis of the current program and a proposal for how CDA could redevelop its patient/public information program to make it more dynamic, more useful, more popular -- and more profitable.

The plan presented here calls for the replacement of the current pamphlet series with a new three-component program carrying DAP's "GOOD FOR LIFE" identity:

- o Fact Sheets on topics in demand
- o A consumer-oriented booklet series
- o A poster information series

The new program offers a broader range of products targeted to meet specific needs both in the dental office and in public awareness and education. A combination of increased and sustained promotion and reduced pricing/unit of information will make CDA products both more accessible and more popular. Appropriate mark-ups will ensure that the program is "profitable".

TIME FOR A CHANGE

CIS has long recognized that the current pamphlet program is in need of a serious overhaul:

- o Many pamphlets are now out-of-date
- o New pamphlets take too long to develop
- o Pamphlets are, relatively speaking, expensive for users
- o Awareness of pamphlets appears low among dentists, auxiliaries, public health programmers, educators and corporate health officers
- o Pamphlets should reflect and carry the "Good For Life" theme
- o Sales are virtually static at approximately 500,000/year
- o The sale of materials should generate revenues to make the program "profitable".

A WHOLE NEW BALL GAME

After considering the above issues, reviewing the existing pamphlets, the sales patterns and the identified needs of the dental office, and other key markets for CDA information, Manifest recommends:

A New Information Product Mix:

REPLACE CURRENT PAMPHLETS WITH FACT SHEETS

- o wind up CDA's current pamphlet program completely
- o replace pamphlets with a "GOOD FOR LIFE" FACT SHEET program
- o cover topics with an identifiable demand in dental offices and public health programs

DEVELOP A CONSUMER-ORIENTED BOOKLET SERIES

- o establish a consumer information booklet series on subjects such as: dental insurance, the dollars and sense of dental care, how to find a dentist, advice for the fearful patient, cosmetic dentistry.

DEVELOP A POSTER INFORMATION SERIES

- o posters help dentists make the office a communicating environment
- o CDA already has an inventory of "Support Your Teeth" posters
- o the "Stinger" ad campaign lends itself to bulletin board-sized posters
- o further posters will be created for Dental Health Month and with sponsor support

A dramatically expanded promotion campaign targeted to major markets for CDA information products:

- o major ad campaign in the Journal o monthly
- o direct mail promotion, sampling and order forms in Communique mailings and membership renewal mailing to CDA members
- o promotion of materials, how to use them and how they are working for others in DAP vehicles including: Journal Update, Dental Awareness Program Report, and CDA "Dental Awareness In The Office" Seminars
- o promotion to non-member dentists with emphasis on discounts for members as part of membership drive
- o visible promotion at CDA and provincial conventions at CDA booth
- o direct mail/promotion and sampling to public health units with special institutional volume discounts
- o periodic mailings of re-order forms to established clients

A rationalized pricing structure that makes information products more accessible (ie, cheaper) for customers and more profitable for CDA

- o develop consistent, across the board pricing. For example, fact sheets could be sold at \$ 4.00/100 as compared to current pamphlet prices ranging from \$ 9 - \$ 20/100 (including postage and handling)
- o quote postage and handling as an additional cost item
- o ensure CDA a gross mark-up of 50% to ensure profitability on all products: pamphlets, posters and fact sneets

Maintaining an adequate inventory of materials to ensure CDA's ability to fulfill orders in a timely manner

- o orders should be processed immediately
- o shipments should arrive at destinations within three weeks of post-marked order
- o reprint volume should be set to maximize price breaks

On-going market research on information needs, and effectiveness of the program

- o periodic needs assessment surveys
- o track orders and maintain client mailing lists
- o periodic checks on timeliness of order fulfillment
- o periodic awareness surveys to determine whether or not promotion is reaching target markets

GREATER CHOICE + GREATER UTILITY + GREATER RETURNS

The proposed new CDA patient/public information program will provide current and potential clients with a far greater choice of information products from which to choose. The products themselves are designed to maximize their utility both in offices and in public health programs. The appeal and the accessibility of the products will be greatly enhanced by increased promotion and dramatically reduced pricing. Appropriate mark-ups ensure CDA a fair return on every sale. Increased volume will generate significant financial returns that should enable the program to not only be self-supporting but also to offset administrative and staff costs associated with the program.

The central element of the new program can be up and running in approximately two months. Promotion can coincide with the launch of the new program. Returns should begin in early 1987.

14-Jan-87

CANADIAN DENTAL ASSOCIATION
DENTAL HEALTH PAMPHLETS
PAMPHLET SALES - 1986

CODE	ENGLISH PAMPHLETS	PAMPHLETS SOLD AS AT SEPT 30/86	PAMPHLETS SOLD OCTOBER - DECEMBER 31, 1986	TOTAL PAMPHLETS SOLD	PRICE/100 AS AT SEPT 30/86	PRICE /100 AS AT OCT 1/86	TOTAL SALES	LESS: COST OF GOODS SOLD	GROSS PROFIT	REMAINING INVENTORY
1	Are You Missing A Few Teeth?	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
2	Be a Healthy Smoker Or Quit	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
3	Care Following Minor Oral Surgery	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
4	Those Important Baby Teeth	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
5	Repaid Dental Insurance	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
6	Facte Pour Floxidation	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
7	Do You Need Copelets Denture	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
8	Eating Properly For Better Dental Health	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
9	Dangerous Infection (Hill/Smith)	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
10	Protect That Mouth	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
11	Save That Tooth	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
12	Do You Sanket Have Your Mouth Checked	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
13	Do It Yourself Oral Hygiene	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
14	TMJ Disorder	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
15	Choosing A Career...Dentistry	2794	1337	3415	0.19	0.19	532.12	1709.30	3612.82	24867
16	41	1833	1682	2414	0.20	0.20	482.80	786.62	187.42	436
17	TOTAL ENGLISH PAMPHLETS	388412	195542	583954			70056.62	38170.56	34925.58	214079

FRENCH PAMPHLETS

1	Vous manque-t-il des dents ?	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
2	Les dentiers dentures...	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
3	Precautions prendre apres chirurgie	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
4	Ses preagres dents	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
5	Le guide du consommateur...	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
6	Fluoration: les faits parlent d'eux memes	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
7	Vous faut-il des dentiers	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
8	La sante dentaire grace...	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
9	souffrez vous de periodontite	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
10	Soignez votre bouche	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
11	Pratiques d'hygiene	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
12	Vous aimez-vous assainir la bouche	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
13	Derangement de l'ATM	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
14	Vous choisissez une carriere...	3708	1269	5917	0.19	0.19	909.94	347.38	643.89	5693
15	TOTAL FRENCH PAMPHLETS	95192	35552	132714			17432.18	13526.40	3605.777	64585
16	TOTAL PAMPHLETS	404604	233104	727708			91528.8	52797.37	38731.42	328774

PAMPHLET ORDERING RATIO

DENTISTS	90.8
HOSPITALS	10.0
GENERAL PRACTICE	1.1
TOTAL	100.0

APPENDIX III

BUDGET

DAP Seminars

Consulting Fee/Seminar leader(s)	\$2,000
Travel & Accommodation up to	\$1,000
CDA Administrative Fee* (per booking)	\$1,000
Seminar Materials** \$50.00 per kit X 20	\$1,000
	\$5,000

* CDA administrative costs include initial development costs and overall administration of the seminars.

** Costs are based on a minimum of 20 attendees. Additional kits will cost \$50.00 each.

APPENDIX IV

1986 Year-End Figures (Unaudited)

DHM and DAP

<u>Revenue</u>	1986 Budget	1986 Actual
DHM	\$20,000	\$80,560
DAP	—	\$196,160
<u>Expenses</u>		
DHM	\$75,000	\$69,090
DAP	\$187,000	\$415,318
Administration	\$30,000	\$21,714

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Members of the CDSPI Board of Directors are:

Dr. G. Anthony, Atlantic Provinces
Dr. G.F. Copithorne, British Columbia
Dr. J.M. Dillon, Manitoba
Dr. G. Dubé, CDA
Dr. D. Montminy, Québec
Dr. R.L. Rasmussen, Alberta
Dr. R.R. Schiewe, Ontario
Dr. R.D. Wells, Ontario
Dr. J.N. Wright, CDA

Members of the CDSPI Management Committee are:

Dr. J.E. Durran, President, Burlington
Dr. R.L. Moran, Treasurer, Toronto
Dr. M.D. Charendoff, Secretary, Toronto

Observers at the CDSPI Board are:

Dr. D.W. Allen, Prince Edward Island
Dr. C.R. Hill, Saskatchewan
Dr. R.A. Turcotte, New Brunswick
Dr. G.S. Zwicker, Nova Scotia

This report includes all information that has become available since the Council (CDSPI) Report to the Annual Meeting of the CDA in Halifax in August 1986.

The CDSPI Board met on August 24, 1986, November 29, 1986 and will be meeting on March 6, 1987.

ITEMS OF BUSINESS REQUIRING BOARD ACTION

1. Marketing Concept

Earlier this year consideration was given to a concept relating to a marketing opportunity that has the potential of increasing the average coverage levels for Life Insurance, Long Term Disability and Office Overhead. The concept was presented to our Board and works as follows:

.../2

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

- Imperial Life underwrites an application and approves it.
- We pass on the approval with policy and invoice in the normal administrative process.
- We inform the participant at that time that the insurer will grant them additional coverage up to the original amount approved, or any portion thereof, without a further medical if the offer is accepted in 30 days.
- If not accepted within 30 days, the proposal is void.

Based on the overall review and conceptual approval by Imperial Life of this marketing concept, the Board of Directors of CDSPI recommends the following resolution.

RESOLVED:

- 87.59 **THAT an automatic coverage increase concept, based on current application requests successfully being approved, be used as a marketing technique as outlined; with such technique having a 30-day time frame for acceptance and being limited to overall maximums of each plan.**

ADOPTED

RESOLVED:

- 87.60 **WHEREAS the contract signed by capitation dentists may expose CDA sponsored Professional Liability Insurance Coverage to increased risk factors, CDSPI acting as the Council of insurance and investment of the CDA is instructed to advise the CDA Board at its Annual Meeting in September on whether it is necessary to shelter the majority of Canadian dentists and their patients, possibly including dentists from Ontario, from unwarranted professional liability risks.**

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

Some of the choices that could be explored would include creating a higher premium for Professional Liability Insurance for capitation dentists, requiring disclosure of contractual arrangements that capitation dentists have entered into or perhaps entirely excluding capitation dentist from CDA Professional Liability Insurance Coverage.

ADOPTED

ITEMS OF BUSINESS FOR INFORMATION

1. Malpractice Information

The distribution of Malpractice information was the subject of a Motion at the Halifax Meeting. Mr. Butler and I attended a portion of the Registrars' meeting in Toronto on December 5, 1986 in order to share information with them and also to hear their responses to that Motion.

One province is in the process of implementing a procedure which could require the dentist to state the existence of Malpractice actions against that dentist. The other provinces have, through their Registrars, assured us that they are not about to get involved in making disclosure a contingency for licensing.

CDSPI has discussed this progress with the insurer, and there are other options being considered which will be reported if found to be feasible.

2. CDIP Eligibility

The direction of the CDA Board in August 1986 was that the Board requested a list of organizations which would be covered by this Motion. The original Motion was reviewed further and, as a result, we felt it would not be appropriate to attach the names of the organizations to this Motion. A new Motion was sent to the Executive Director of the CDA on September 5, 1986 and by his letter of November 10, 1986, the amended Motion is being brought to the Board of Governors' attention via the Executive Council's Report.

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

3. Life Surplus Management

This topic has been studied for a number of years, and there have been a number of opinions expressed which have supported various methods of management of that Life Surplus.

At the present time, we are monitoring the response of the participants to the distribution of \$658,000, which occurred on January 1, 1987 for those who carry Basic Life Insurance.

Although the final experience reports for the Plan Year 1986 will not be available until mid-March, there is enough information available to tell you that there will probably be no increase in the Life Surplus as a result of the experience (deaths) which occurred in 1986.

Any further recommendations regarding management of the Life Surplus will have to await the completion of studies that are being done for presentation to the CDSPI Board (acting as your Council) and then recommendations from that body to you in our next report.

4. Malpractice Coverage

The Board should be aware that the extension of coverage which was available as an automatic benefit to estates of deceased dentists has been modified as a result of a unilateral action of the reinsurers. Previously, there was an automatic extension for a five year period. This has been shortened to two years, with the comment that this period of time is all that is required as a result of the Statute of Limitations. At the present time, the accuracy of that statement is being verified and a confirmation will be available at the Board Meeting.

5. CDSPI Restructured Board

The new Board held its first meeting on November 29, 1986 and despite a long agenda, the participants made the first meeting a success.

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

6. Experience Reports - 1986

As mentioned elsewhere in this report, the Annual Report will not be available until mid-March. Further, since there can be relatively large swings in experience during any quarter of the year, it would be wise to await the final figures before attempting any analysis.

As an aside to this subject, I can assure the Board that dentists have a Malpractice market for 1988.

7. CDA RSP

Currently, we are all basking in the glow from the success of the performance of these plans.

The CDSPI Management Committee meets quarterly with the Investment Managers and we hope that the participants are pleased with the quarterly publication as well as the results. Attached (Schedule A and B) are the stats on participation, etc., at December 31, 1986 with comparative figures for 1985.

8. Retirement Counselling

1987 will see Retirement Counselling Seminars given at eleven locations. Attached as Schedule C is the 1987 Registration Form which provides details. This service is in a growing stage, and it is a pleasure to be able to report that Victoria and Vancouver have enrollments of 24 and 55, respectively, as at January 23, 1987. This represents a 139% increase over last year for the Province of British Columbia. The positive comments made by previous attendees are starting to show results.

9. Dentists' Staff Package

At the August meeting of the CDA, it was agreed that CDSPI should make available a staff benefits package which would make it convenient for dentists to provide some benefits to their staff at a very competitive cost.

As at January 23, 1987, there are 265 participants.

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

10. Umbrella Coverage

The Personal Umbrella Liability Program now has contract wording finalized and promotional announcements are being completed for a mailing the last week of February 1987. Applicants will have coverage taking effect April 1, 1987.

Respectfully submitted,

J.E. Durran, D.D.S.
Chairman
Council on Investment and Insurance
President
Canadian Dental Service Plans Inc.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Insurance and Investment with appreciation.

Schedule A

CDA RSP GROWTH

MONTH: DECEMBER 1986PLAN YEAR 1986

	\$ Current Month	\$ Year-to-Date 1986	\$ Year-to-Date 1985	% Increase (Decrease)
NEW ACCOUNTS	35*	215	118	82%
<u>CONTRIBUTIONS:</u>				
Fixed Income	62,441.58	1,495,287.69	612,077.86	144%
Common Stock	178,760.58	2,523,012.05	558,608.23	351%
Money Market	87,278.16	1,190,037.62	911,819.11	31%
Balanced Fund	<u>80,257.04</u>	<u>1,422,392.82</u>	<u>229,555.15</u>	520%
Sub-Total	408,737.36	6,630,730.18	2,312,060.35	187%
Guaranteed Fund				
1-Year	3,144.00	101,107.59	60,480.62	67%
2-Year	3,000.00	45,671.08	--	--
3-Year	--	117,496.08	45,766.03	157%
4-Year	--	--	--	--
5-Year	<u>5,000.00</u>	<u>76,982.54</u>	<u>103,920.97</u>	(26)%
Sub-Total	11,144.00	341,257.29	210,167.62	62%
TOTAL CONTRIBUTIONS (includes Transfers-in)	<u>419,881.36</u>	<u>6,971,987.47</u>	<u>2,522,227.97</u>	176%
<u>TRANSFERS-IN:</u>				
Number of Transfers	25	525	218	141%
Amount \$	184,028.17	5,321,100.98	1,570,717.29	239%
NET CONTRIBUTIONS	235,853.19	1,650,886.49	951,510.68	74%
<u>DE-REGISTRATIONS:</u>				
Number of Accounts	7	96	70	37%
Amount \$	202,536.36	3,085,992.12	2,361,061.50	31%
<u>NET GAIN (LOSS):</u>				
Number of Accounts	28	119	48	148%
Amount \$	217,345.00	3,885,995.35	161,166.47	
TOTAL # OF ACCOUNTS		1,902	1,452	31%
<u>Comments:</u> See separate report attached				

RSP DE-REGISTRATIONS
COMPOSITION

MONTH: December 1986

PLAN YEAR: 1986

TYPE	Current Month No.	Current Month \$	Year-to-Date 1986 No.	Year-to-Date 1986 \$	Year-to-Date 1985 No.	Year-to-Date 1985 \$	Increase (Decrease) % - \$
<u>OTHER RSP's:</u>							
Self-Directed	-	-	15	508,013.33	10	299,127.50	
G.I.C.'s	-	-	1	12,884.66	5	127,426.04	
Other	2	73,924.50	19	251,928.15	13	335,995.63	
Sub-Total	2	73,924.50	35	772,826.14	28	762,549.17	1%
RRIFs	-	-	6	553,029.77	-	-	
Annuities	1	79,561.86	13	740,037.44	16	1,027,919.89	
Death Benefits	-	-	9	754,475.33	6	370,927.75	
Cash Withdrawals	4	49,050.00	33	255,205.62	20	155,475.66	
Ref.Excess Cont.	-	-	-	10,417.82	-	2,859.00	
Miscellaneous	-	-	-	-	-	-	
Total	7	202,536.36	96	3,085,992.12	70	2,319,731.47	33%

CDSPI RETIREMENT COUNSELLING SEMINAR 1987

REGISTRATION FORM

I (We) wish to register for the following CDSPI Retirement Counselling Seminar:

- | | | |
|--|----------------------|-----------------------|
| ☐ Thursday February 5, 1987 | Victoria, B.C. | Oak Bay Beach Hotel |
| ☐ Friday February 6, 1987 | Vancouver, B.C. | Westin Bayshore Hotel |
| ☐ Friday March 27, 1987 | Edmonton, Alta. | Westin Hotel |
| ☐ Friday April 3, 1987 | St. Catherines, Ont. | Beacon Motor Inn |
| ☐ Friday April 10, 1987 | Regina, Sask. | Landmark Inn |
| ☐ Friday May 8, 1987 | Toronto, Ont. | L'Hotel |
| ☐ Friday June 5, 1987 | Thunder Bay, Ont. | Valhalla Inn |
| ☐ Friday Sept. 11, 1987 | Ottawa, Ont. | Westin Hotel |
| ☐ Friday Sept. 18, 1987 | London, Ont. | Holiday Inn |
| ☐ Friday October 2, 1987 | Montreal, Que.* | Ritz Carlton |
| ☐ Thursday October 23, 1987 | Halifax, N.S. | Halifax Sheraton |

*Presented in English with simultaneous translation - Course Material in English only.

I enclose my cheque, payable to CDSPI for:

- ☐ \$175.00 - CDSPI participants ☐ \$225.00 - Non CDSPI participants

Spouse free if accompanied by registrant BUT must be registered in order to attend

Name of Registrant: _____ Age: _____
(Please print clearly for name badge purposes)

Address: _____

_____ Postal Code: _____

Spouse (if attending) _____ Age: _____

May we have a telephone number in the event that we must contact you () _____



**Canadian
Dental
Service
Plans Inc.**

- Please return Registration Form together with your cheque to:
Retirement Services Department
CDSPI
Suite 600, 2 Lansing Square
Willowdale, Ontario M2J 4Z3
- Retain the accompanying brochure for seminar details and cancellation refund policy.

COUNCIL ON STUDENT AFFAIRS

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Council Members: Mr. Robert Barr, Chairman, University of Manitoba
Mr. Rick Odegaard, University of British Columbia
Mr. Dave Chorkwa, University of Alberta
Mr. Robin Slowenko, University of Saskatchewan
Mr. Donald Chin, University of Manitoba
Mr. Edward Lee, University of Toronto
Miss Madelaine Shildkraut, McGill University
Miss Wendy Street, University of Western Ontario
Mr. Francois Chartrand, Université de Montréal
Mr. Jacques Brouillet, Université Laval
Mr. Doug Lovely, Dalhousie University
Miss Pam Zakarow, Student Governor, University of Western Ontario
Dr. Sam Sgro, Past Student Governor, Montreal, Que.
Dr. Liliane LeSaux, Past Chairman, London, Ontario

Executive Liaison: Dr. John Christie, Halifax, Nova Scotia

1. Council Meetings

Council has met once since the last Board meeting on September 26, 1986, immediately following the Canadian Dental Students' Conference.

Items Requiring Board Action

2. Capitation - Third Party Dental Plans

After a discussion and review of the current state of capitation in Canada, Council thought that it was important that students be aware of the pros and cons of capitation and that information be made available to students as soon as possible.

Council recommends:

Whereas the issue of capitation is becoming an important issue of which all dentists and dental students should be aware.

COUNCIL ON STUDENT AFFAIRS

RESOLVED:

- 87.61 THAT the Canadian Dental Association make available to all students all information pertaining to capitation in the form of literature and invited speakers to the dental schools.

ADOPTED

Items Not Requiring Board Action

3. Revisions - Practice Management Manual

Council reviewed the proposed change and additions to the CDA's Practice Management Manual as outlined by Dr. Bob Brandon at CDSC'86. Council agreed to review the draft materials submitted by Dr. Brandon on Recall Systems, Stress, and Emerging Modes of Dental Systems (Capitation). In addition, Council expects to receive from Dr. Brandon additional chapters on Computerization, Insurance and Investment and Interpersonal Communication Skills.

4. Student Membership Fees 1987-88

It was noted by Council that in 1983, Council recommended to CDA that the student membership fee be set at 6% of the CDA active fee. Council reviewed this recommendation in light of the increase in student fees in 1986 from \$13.00 to \$14.00 and recommended a second increase in 1987 to \$16.00. Council concluded that despite their reluctance to increase fees, they had a responsibility to the CDA to ensure that students paid a proportional share of the expenses incurred as a result of the benefits accrued to student members of the Association.

5. Full Journal Circulation

Council discussed how this policy would affect student membership. Council felt that some students would protest paying a membership fee when non-members receive the same benefit. In general, however, it did not appear to be a major concern since Journals are distributed in bulk to the schools.

COUNCIL ON STUDENT AFFAIRS

6. Dental Awareness Program

Dr. Christie provided Council with the background and a current update of the CDA's Dental Awareness Program. Council is excited to learn that the program is being well received by the public and the profession, and would welcome suggestions on how dental students can become more involved.

7. Prelicensure and the Current Dental Curriculum

Council reviewed at length the idea of a prelicensure period. In general, Council did not favor a prelicensure period. Council does feel that changes could be made to the predental requirements and curriculum that would provide more time in dental school for greater practical experience. Council members are collecting more information on their curriculum and student bodies' views on prelicensure for Council's next meeting. This information will be turned over to the Student Governor who will present this information in the form of a position paper to the CDA Council on Education and the ACFD.

8. The Canadian Fund for Dental Education

Council reasserted its commitment to actively support the CFDE in the dental schools. Council felt that the CFDE should develop tools that CDA student reps can use to encourage student awareness and support of the CFDE.

9. NDEB

Council reviewed licensure requirements in each province and the status of NDEB's Certificate of Portability. Council noted that Quebec does not fully recognize the NDEB Certificate. Council is requesting information and clarification from the Order of Dentists of Quebec regarding the reasons why the ODQ does not recognize the NDEB Certificate of Portability based on the accreditation process.

10. ACFD June Conference-Teacher/Educator/Researcher Issue

Following a report on the ACFD Conference in June 1986, Council members expressed concern on the quality of teaching at the faculties, and faculty incentive. Students are concerned that dental faculties are hired and rewarded for their research skills. Students feel faculty are not provided incentives to upgrade their teaching skills nor are good teachers given a great deal of recognition. Council feels it was important that teaching skills receive a greater emphasis in the evaluation and hiring process.

COUNCIL ON STUDENT AFFAIRS

Council requested that the ACFD and the Council on Education be made aware of the CSA's concern in this area, and that more information be provided to Council on this subject by ACFD in the future.

11. CDSC'87

The 1987 Canadian Dental Students' Conference is scheduled to be held in Saskatoon, Saskatchewan, from September 23-26, 1987.

12. CDA Election Results and Representation to Other Meetings

At the last meeting of Council, elections to the positions of Governor-Elect and Chairman-Elect, occurred. Mr. Doug Lovely, Dalhousie University and Miss Madelaine Shildkraut, McGill University, now hold these positions, respectively.

Representatives designated to attend other meetings are:

National Dental Examining Board of Canada - Sam Sgro
The Association of the Canadian Faculties of Dentistry - Bob Barr
The CDA Council on Education - Pam Zakarow
The American Dental Student Association - Bob Barr
The CDA April Board - Bob Barr; Pam Zakarow; Doug Lovely

13. Summary

On behalf of the Council on Student Affairs, I would like to express appreciation for the guidance, support and fellowship of our executive liaison, Dr. John Christie, who has now ended his term on Council.

I would also like to express the appreciation of the CSA, on behalf of all Canadian dental students, to the Canadian Dental Association for its continuing support of this Council, and in allowing us to become a part of organized dentistry in Canada.

Respectfully submitted,

Mr. Bob Barr
Chairman
Council on Student Affairs

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Student Affairs with appreciation.

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY/
L'ASSOCIATION DES FACULTES DENTAIRES DU CANADA

REPORT TO THE 1987 INTERIM BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

I. Our Profession - Our/Its Future

Since the last meeting of the Board of Governors there has been a significant and extremely important meeting between the CDA's Professional Resource Utilization Committee (PRUC) and the ACFD - namely the ten dental deans and the President.

The urgency of the "manpower issue" has brought these groups together to focus on our profession's future. Each of us has concerns and all have varying perspectives which must be shared with and understood by the other. This is finally happening and is evidence of a new beginning. To that end, ACFD has decided to put its Task Force on the "Future of Dental Education" on "hold" for the moment, and instead focus its efforts on developing and furthering this new and closer relationship.

Decisions regarding the future must be soundly-based and be made together. Therefore, due to the urgency of these matters the ACFD has recommended to the Council on Education and Accreditation that the 1987 CDA Teaching Conference on Continuing Education be postponed. In its place, it has been recommended that this year's Teaching Conference compliment the conjoint efforts of the national groups by addressing "Strategic Planning for the Future of Dentistry in Canada". Strategic planning is much talked about these days, however not many are familiar with the different methodologies and approaches that can be critically applied to a particular situation or problem. We believe this will help strengthen and formalize our future expectations and decision making.

II. The Curriculum of the Future

Although the original Task Force is in limbo, the Curriculum Coordinators of the dental schools will meet in June in Vancouver, prior to the Association's House of Delegates meeting, to discuss local and national trends in curriculum development and implementation. Quality dental education must continue and this type of activity supported by the dental faculties helps each institution meet the demands that are before us. We must maintain our profession at the highest possible level, and therefore educate our future practitioners in a way that they will be able to meet those challenges of the future.

.../2

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY/
L'ASSOCIATION DES FACULTES DENTAIRE DU CANADA

III. Summer Teaching Institute and Summer Management Institute

I reported earlier this year on the success of the 1986 Summer Teaching Institute supported through the generous sponsorship of the Canadian Fund for Dental Education and the dental faculties.

This year the Summer Teaching Institute will have a new component that will run concurrently, that is the Management Institute. This is management in a sense of management of the faculty, its objectives, its program and personnel. By all indications, this promises to be very popular and is a very much needed faculty development program which can specifically address the needs of administration within our dental institutions.

IV. Electronic Mail and Conferencing

Electronic Mail has broken the time and distance barrier for ACFD! It is a wonderfully simple, efficient and cost saving way to communicate across our vast country. ACFD hopes that other national bodies, like the CDA, will become actively involved in such a common network which can only benefit us all from both a communication and cost saving perspective.

As always, ACFD and its members are striving to support and advance the quality of the dental profession in Canada, and look forward to an opportunity to contribute positively to such endeavours.

Respectfully submitted,

Marcia A. Boyd, President

ADOPTION OF REPORT

The report of the Association of Canadian Faculties of Dentistry received as information by the Board of Governors, with thanks.

CANADIAN FUND FOR DENTAL EDUCATION

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

1. Since reporting to your Board's 1986 Annual Meeting, CFDE has held its Management Committee Meeting, which took place in Ottawa on January 26, 1987. Unfortunately, due to illness, I was unable to attend, but understand that it was a successful meeting. I am pleased to report on the Management Committee's deliberations and CFDE's activities since my last report.

Items for Information - Not Requiring Board Action

2. Relocation of Headquarters

I am pleased to note that as of October 1, 1986 CFDE has been housed in the CDA building in Ottawa. Unfortunately, our employee of 18 years, Miss Ingrid Kleysteuber, chose not to move to Ottawa with the Fund. Her dedication and hard work are truly missed.

CFDE is now being run on a day-to-day basis by Ms Janice Forsythe in the position of Executive Secretary and Miss Louise Préfontaine as Administrative Assistant.

3. 1986 Income

Our records for 1986 have been closed off and although the audited statement has not yet been prepared, I am confident that the figures are correct.

Total income from all sources was \$281,979 which is down from last year's high of \$300,532. Operational income was \$231,979 and endowment fund gifts totalled \$50,000. This generous endowment was an addition to the current MacLachlan Foundation endowment of \$100,000.

I am sorry to note that in 1986 dentists' personal gifts to the fund were down from \$91,423 to \$80,762.

Donations from dental organizations were up from \$25,639 to \$26,901. Business and industry support has decreased to \$43,687 but plans are underway for a much more aggressive marketing campaign to industry in 1987.

CANADIAN FUND FOR DENTAL EDUCATION

Gifts to our living memorial fund decreased from \$11,510 to \$7,015 in 1986 and tributes were up from \$1,323 to \$1,855.

Support from the hygienists has increased substantially from \$865 to \$1,345. We hope that this is a trend which will be continued in years to come.

4. 1986 Disbursements

The CFDE Trustees approved grants totalling \$174,568 for 1986. This was cut back from last year's total as it was expected that income in 1986 would be down.

5. 1986 Operating Expenses

Operating expenses for 1986 increased from \$96,720 to \$110,610. A substantial amount of this was for staff settlement expense.

6. Management Committee Meeting

As you can see, donations to the fund this year are down significantly. The Management Committee has examined the situation and is taking steps to dramatically increase next year's revenues.

One of the main fundraising projects planned is a lottery, with the prize being an all expenses paid trip for two to the 1987 FDI annual meeting in Buenos Aires. Due to licensing laws, the lottery can only be actively promoted in Ontario. However, tickets will be available from the fund's trustees and office staff for \$25 each. The draw will take place at the ODA convention on May 12, 1987. We hope to sell at least 2000 tickets and raise \$50,000 for the Fund.

In addition to the lottery, we plan to change our approach to soliciting funds from business and industry. The CFDE Board will discuss a new marketing plan at its meeting in April. All marketing strategies for 1987 will emphasize CFDE's 25th Anniversary. It is hoped that 1987 will be a landmark year for the Fund.

CANADIAN FUND FOR DENTAL EDUCATION

7. Appreciation

Although the fund did not reach its goals in 1986, it still made a significant contribution to dentistry. CFDE's accomplishments were made possible through the support of all those who gave so generously. On behalf of my fellow Trustees and all those who benefited from the fund's support, may I express my most sincere appreciation.

Once again this year, the national and provincial dental associations offered tremendous support to CFDE. Not only is their financial assistance appreciated but also the other ways they support the Fund, such as through placing ads in their publications and promoting CFDE at their meetings.

Again, to all those who gave to CFDE in 1986, I extend my thanks. I hope that CFDE can look forward to your continued support in 1987, the year of the Fund's 25th Anniversary.

Respectfully submitted,

J. Fred Reid, D.D.S.
Chairman
CFDE Board of Trustees

ADOPTION OF REPORT

The report of the Canadian Fund for Dental Education received as information by the Board of Governors, with thanks.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS MEETING

Items for Information - Not Requiring Board Action

In accordance with the Act of Parliament, the purpose of the National Dental Examining Board of Canada is to establish qualifying conditions and issue certificates to dentists who meet the standards of the Board.

The Board is privileged to have educators as members. The interaction between educators and general practitioners adds greatly to the calibre of the discussions.

I. CERTIFICATION

1. Current Graduates via Accreditation

Statistics - Appendix I

The Board is legally responsible for any mechanism it utilizes for certification. Accordingly, the Board annually reviews its relationship with the CDA Council on Education and Accreditation and whether the accreditation process meets the needs of the Board.

2. Examinations

Statistics - Appendix II

The clinical examination structure was altered in 1986 and is working well, the major change being the expansion and weighting of the section on Evaluation, Diagnosis and Management of Patients.

In order for the Board to maintain the validity and reliability of its examination process, a continuous monitoring takes place of the interrelationship and relevance of the various examination components and of the evaluation criteria. The Board office also actively seeks information of new developments from other examination jurisdictions.

During the Annual Meeting, members of the Board acted as candidates and took a portion of a written examination on a self-evaluation basis. The reaction to this was very positive and a similar exercise was suggested for future meetings.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

II. THE BOARD AND THE LAW

The Board is at present in the appeals stage in its argument that complaints against the Board be investigated by the Federal Rights Commission rather than falling under provincial jurisdictions. The appeal is expected to be heard in the Ontario Court of Appeal early in 1987.

III. STUDENTS

The exchange of representatives between the CDA Council on Student Affairs and the Board has resulted in a better understanding and appreciation of the function of the Board.

IV. CDA COUNCIL ON EDUCATION AND ACCREDITATION

1. Accreditation Guideline

As a result of a request from the Provincial Board of Nova Scotia, the following motion was carried:

"That the Board request the CDA Council on Education and Accreditation to review its accreditation guidelines in regard to the management of students admitted with advanced standing to an undergraduate dental program in a university in Canada."

2. Clinical Pilot Review

The Board expressed its approval of the inclusion of this program in the accreditation process.

3. Prelicensure Conference

The Conference proceedings were reviewed and thanks were expressed by the Chairman of the Conference for the Board's participation and financial support.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

4. CDA/ADA Reciprocity

The Board perused the Brief on Reciprocity as submitted to the ADA Council on Dental Education and received thanks from the Chairman of the Council on Education and Accreditation for the Board's participation in the preparation of the Brief.

5. Report of Committee on CE

The Board was brought up to date on the pilot project and members were encouraged to participate.

If our profession is to retain its self-governing status, it will have to be more responsive to the needs and demands of an increasingly health and cost conscious public. Our responses will have to include not only the assurance of competence at the time of admittance to the profession but also throughout the lifetime of the professional. Provincial and national organizations will be expected to take a more active role in assisting the practitioner in this task.

V. ADDRESS BY CDA PRESIDENT

The Board was honoured to be addressed by the President of the CDA, who stated that the relationship between the two organizations was at an all-time high and that the CDA was very aware of the Board's importance in organized dentistry and Canadian society.

VI. DENTAL HYGIENE CERTIFICATION EXAMINATION

As a result of a motion from the Council on Education and Accreditation, a meeting had taken place between CDA, CDHA and NDEB representatives to explore a national certification mechanism for dental hygienists.

Prior to this meeting, the Board had obtained advice from its legal counsel which clearly stated that, under the present Act of Parliament, the Board cannot be legally responsible for such a mechanism.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

The consensus was that, in view of the present political climate and the costs involved, the Board's Act of Parliament should not be amended at this time. The Board is, however, prepared to offer its examination expertise, at cost, to any organization who may assume legal responsibility for the certification of hygienists.

The Board referred this matter back to the Council on Education and Accreditation.

VII. NDEB/RCDC

The RCDC President addressed the Board and stated that the RCDC Executive Committee will consider official NDEB representation on the RCDC Council.

VIII. FINANCES

The Board's financial position is sound and the Budget reflects a 5% fee increase.

IX. CERTIFICATES OF MERIT

Certificates of merit were presented to Dr. W.J. O'Driscoll who is retiring from the Board after many years of service, and to Dr. G.S. Beagrie, the appointee from the Council on Education and Accreditation whose term expires in 1987.

X. OFFICERS OF THE BOARD FOR 1987

President	Dr. H.M. Dick
President-Elect	Dr. R.E. Jordan
Past-President	Dr. R.B. Gilliland
Registrar	Dr. G. Kravis
Administrative Officer	Mrs. F. Dawes

NATIONAL DENTAL EXAMINING BOARD OF CANADA

XI. MEETING DATES - 1987

Executive Committee	April 12 & 13	Toronto
Executive Committee	November 8	Ottawa
Annual Meeting	November 9 & 10	Ottawa

XII. EXAMINATION DATES - 1987

Written		May 11, 12 & 13, 1987	*
Clinical	- PART A	May 19, 20 & 21, 1987	Montreal
	- PART B	May 22, 25 & 26, 1987	Montreal
	- PART C	May 27, 28 & 29, 1987	Montreal
Comprehensive		May 11 - 29, 1987	Montreal
Clinical	- PART A	Aug. 4, 5 & 6, 1987	Vancouver
	- PART B	Aug. 7, 10 & 11, 1987	Vancouver
	- PART C	Aug. 12, 13 & 14, 1987	Vancouver
Written		Oct. 19, 20 & 21, 1987	*
Clinical Part C			
Supplemental		Dec. 17, 18 & 19, 1987	Montreal

* - Selected University Centres

Respectfully submitted,

G. Kravis, DDS
Registrar

ADOPTION OF REPORT

The report of the National Dental Examining Board of Canada received as information by the Board of Governors, with thanks.

NDEB CERTIFICATES
issued to
CURRENT GRADUATES WITHOUT EXAMINATION

FACULTY	1971		1972		1973		1974		1975		1976		1977		1978	
	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.
ALTA.	47	47	51	51	38	38	50	50	45	45	42	42	39	39	51	50
B.C.	19	18	28	28	34	34	36	36	38	38	35	35	36	36	38	38
DALH.	22	22	23	23	24	24	30	29	22	22	29	29	29	29	26	26
LAVAL	-	-	-	-	-	-	-	-	10	10	16	14	7	7	14	14
MAN.	28	28	24	24	26	25	30	30	28	28	26	26	26	26	25	25
McGILL	38	38	35	35	38	38	37	37	42	42	40	40	40	40	42	40
MTL.	74	67	67	66	78	73	79	72	77	51	78	76	77	67	79	78
SASK.	-	-	10	10	-	-	9	9	10	10	15	15	11	11	10	9
TORONTO	131	97	124	100	125	119	127	112	118	114	123	115	130	119	126	122
U.W.O.	10	10	30	30	34	34	52	52	43	43	50	50	53	53	56	55
TOTAL	369	327	392	367	397	385	450	427	433	403	454	442	448	427	467	457

NDEB CERTIFICATES
issued to

CURRENT GRADUATES WITHOUT EXAMINATION

FACULTY	1979		1980		1981		1982		1983		1984		1985		1986	
	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.
ALTA.	46	46	45	45	43	43	49	49	48	48	47	47	43	43	47	47
B.C.	41	41	36	36	39	39	37	37	42	41	38	38	39	39	33	33
L.H.	24	24	25	25	26	26	27	27	26	26	23	23	33	32	34	34
VAL	23	22	24	24	23	23	19	19	21	19	23	23	31	30	37	34
MAN.	28	28	32	32	27	27	27	27	36	36	23	23	22	22	24	24
McGILL	43	43	37	37	42	42	37	37	37	35	36	35	40	39	38	38
MTL.	81	79	80	77	84	80	82	80	78	74	74	72	76	73	78	68
SASK.	13	13	20	20	19	19	19	19	22	22	23	23	21	21	22	22
TORONTO	125	116	132	124	120	113	127	120	123	121	117	107	118	108	113	102
U.W.O.	48	48	58	58	54	54	50	50	53	53	54	54	55	55	54	54
TOTAL	472	460	489	478	477	466	474	465	486	475	458	445	478	462	480	456

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - UNAPPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		PRECLINICAL		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1971	41	54	22	91	20	20
May 1972	44	59	26	69	27	33
May 1973	42	48	23	78	25	32
Oct 1973	7	29				
May 1974	35	69	27	85	37	43
Oct 1974	11	30				
May 1975	51	63	35	74	28	39
Nov 1975	28	57				
May 1976	61	62	46	54	48	33
Nov 1976	30	63				
May 1977	59	63	64	55	36	53
Aug 1977					29	48
Oct 1977	34	44				
Dec 1977					4	75
May 1978	52	65	63	54	27	48
Aug 1978					21	33
Oct 1978	28	64				
May 1979	38	68	71	38	32	31
Aug 1979					17	37
Oct 1979	27	59				
May 1980	53	64	49	45	39	31
Aug 1980			31	52	20	25
Oct 1980	41	51				
May 1981	55	69	56	48	42	33
Aug 1981			29	41	22	36
Oct 1981	40	40				
Dec 1981					7	0

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - UNAPPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		PRECLINICAL		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1982	68	62	53	42	32	28
Aug 1982			30	34	25	24
Oct 1982	52	46				
Dec 1982					4	75
May 1983	85	54	71	30	40	33
Aug 1983			51	59	29	28
Oct 1983	54	41				
Dec 1983					8	100
May 1984	71	55	56	54	37	14
Aug 1984			38	47	48	17
Oct 1984	49	41				
Dec 1984					8	38
May 1985	76	37	47	38	54	7
Aug 1985			41	41	44	27
Oct 1985	50	30				
Dec 1985					32	50

APPENDIX II-4

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - APPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1971	32	63	-	-
Oct 1971	2	100	-	-
May 1972	47	87	-	-
Sept 1972	4	75	-	-
May 1973	30	80	-	-
Oct 1973	12	92	-	-
May 1974	38	95	-	-
Oct 1974	15	87	-	-
May 1975	31	90	-	-
Nov 1975	20	95	-	-
May 1976	36	92	-	-
Nov 1976	26	92	-	-
May 1977	56	91	-	-
Oct 1977	36	86	-	-
May 1978	26	92	-	-
Oct 1978	48	92	-	-
May 1979	9	100	3	33
Aug 1979			2	50
Oct 1979	13	92		
May 1980	23	100	11	27
Aug 1980			4	50
Oct 1980	14	100		
May 1981	12	100	8	25
Aug 1981			8	25
Oct 1981	4	100		

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - APPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1982	17	94	6	33
Aug 1982			16	31
Oct 1982	4	100		
Dec 1982			2	0
May 1983	7	100	6	0
Aug 1983			7	57
Oct 1983	9	100	-	-
May 1984	3	100	9	44
Aug 1984			4	25
Oct 1984	7	100		
Dec 1984			2	100
May 1985	9	78	7	0
Aug 1985			6	50
Oct 1985	20	85		
Dec 1985			1	0

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - APPROVED SCHOOLS

[illegible]

THE ROYAL COLLEGE OF DENTISTS OF CANADA

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

Annual Meetings

The 1986 Annual Meeting of the RCDC was held in conjunction with that of the CDA in Halifax in August. Officers and Council members remain the same as when last reported to your Board, with elections for several specialties to be held in 1987.

Fourteen (14) new Fellows and fifteen (15) Members were officially admitted to the College at the Convocation on August 19th, bringing the College's total numbers up to 367 Fellows and 293 Members.

The 1987 Annual Meeting and Convocation will be held on 19th September in Toronto and we hope representatives of the CDA will be able to attend.

Examinations

Under the direction of Examiner-in-Chief Dr. Keith C. Titley, both Fellowship and Membership examinations were held twice in 1986, with favourable reaction from candidates, so that this will be the College's practice for the foreseeable future. Numbers of applicants remain constant and the following represents the results of all the 1986 examinations:

	<u>Fellowship</u>		<u>Membership</u>	
	<u>Pass</u>	<u>Fail</u>	<u>Pass</u>	<u>Fail</u>
Dental Public Health	-	-	-	1
Dental Sciences	1	-	-	-
Endodontics	2	-	-	-
Oral and Max. Surgery	3	5	6	2
Oral Pathology	1	-	2	-
Oral Radiology	1	-	1	-
Orthodontics	-	-	2	-
Pediatric Dentistry	1	-	5	-
Periodontics	1	-	7	-
Prosthodontics	-	-	4	-
	<u>10</u>	<u>5</u>	<u>27</u>	<u>3</u>

THE ROYAL COLLEGE OF DENTISTS OF CANADA

Examinations (Cont'd)

Some of the successful Membership Examination candidates took advantage of the new system and sat both examinations in 1986.

Written examinations were held in Vancouver, Edmonton, Saskatoon, Winnipeg, Toronto, Halifax and Ohio, with the orals in Vancouver and Toronto.

Dr. Robert W. Priddy of Vancouver was appointed Chief Examiner in Oral Pathology effective January, 1986 for a 3-year term, succeeding Dr. R.J. McComb, who now represents the Oral Pathology section on the Council of the College.

Respectfully submitted,

Michael J. Crompton
President

ADOPTION OF REPORT

The report of the Royal College of Dentists of Canada received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF ORAL PATHOLOGY

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS MEETING

Items for Information - Not Requiring Board Action

The 20th annual meeting of the Canadian Academy of Oral Pathology was held at the Toronto Westin Hotel, May 15, 1986. Dr. D. Mock, (University of Toronto) President of the Academy, chaired the meeting.

The Executive and Committees of the Academy for 1986/87 are as follows:

President	Dr. D. Mock	
President Elect	Dr. R.W. Priddy	
Vice-President	Dr. P. Duquette	
Secretary-Treasurer	Dr. J. Lovas	
Immediate Past President	Dr. G.P. Wysocki	
Nominating Committee	Dr. R.J. Brooke	(1 year)
	Dr. T.D. Daley	(2 years)
	Dr. A. Elgeneidy	(3 years)
Membership Committee	Dr. C. Kilmartin	(1 year)
	Dr. S.J. Ahing	(2 years)
	Dr. B. Harsanyi	(3 years)
Professional and Public Relations Committee	Dr. J. Lovas	(1 year)
	Dr. L. Lee	(2 years)
	Dr. J. Epstein	(3 years)

During this past year the Canadian Academy of Oral Pathology completed a survey of active members regarding the question of recognition of Oral Medicine as a dental specialty. At the annual meeting Dr. Mock reviewed the background and events relating to the issue of specialty status for Oral Medicine and read into the minutes the motion passed at the April 3rd meeting of the Specialty Section of the CDA.

The Canadian Academy of Oral Pathology notes that the Board of Governors of the Canadian Dental Association adopted the recommendation of the Council on Education and Accreditation regarding the recognition of Oral Medicine as a dental specialty (Resolution 86.89). The second section of that resolution, is not totally reflective of the Canadian Academy of Oral Pathology's recommendation (unanimously supported by the Specialty Section in April) and seems to leave this matter unresolved.

At the request of the CDA's Council on Information Services, the development of a pamphlet on Oral Cancer has been placed in abeyance.

CANADIAN ACADEMY OF ORAL PATHOLOGY

In order to obtain more accurate records for the CDA's Specialty Register, the Academy's annual dues notice will contain a section to indicate CDA membership status, areas of interest/research and current scientific journal subscription information. The collated data will be made available to the CDA.

Dr. Priddy has agreed to write a history of the Canadian Academy of Oral Pathology and the development of Oral Pathology in Canadian Dentistry.

Respectfully submitted,

R.W. Priddy, DDS, MSc, FRCD(C)
Secretary-Treasurer
Canadian Academy of Oral Pathology

ADOPTION OF REPORT

The report of the Canadian Academy of Oral Pathology received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

I. The Elective Officers of the Academy for 1986-87 are:

President	-	Dr. Frank Pulver
Past-President	-	Dr. Ian Bennett
President-Elect	-	Dr. Arlie Dungy
Secretary-Treasurer	-	Dr. Peter Pronych

II. The Report of the Canadian Academy of Pediatric Dentistry has been forwarded in form of minutes of the Annual Meeting of the General Assembly held in Vancouver in August, 1986.

APPENDIX I

Respectfully submitted,

Dr. Peter Pronych
Secretary/Treasurer

ADOPTION OF REPORT

The report of the Canadian Academy of Pediatric Dentistry received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

Minutes of Annual Meeting
General Assembly
Tuesday, 19 August, 1986

PRESENT:

Dr. Ian Bennett, Dr. Doug Campbell, Dr. V. Chafekar, Dr. W.S. Cheung, Dr. W. Croft, Dr. Jack Derbyshire, Dr. G. Kirkson, Dr. Arlie Dungy, Dr. G.M. Jinks, Dr. David Kennedy, Dr. B. Kuzyk, Dr. Paul MacDonald, Dr. Bruce MacKenzie, Dr. Howard McIsaac, Dr. Alan Milnes, Dr. George Ng, Dr. Bob Patton, Dr. Peter Pronych (Secretary/Treasurer), Dr. Frank Pulver (President), Dr. Bev Richardson, Dr. Joy Richman, Dr. Maret Truuvvert, Dr. Lawrence Yanover.

86-01 CALL TO ORDER

This meeting was called to order at 8:10 a.m. in room # 40 of the Food Sciences Building, University of British Columbia, Vancouver, British Columbia. Dr. Frank Pulver, in the chair, presented the agenda (appendix I) to the General Assembly.

86-02 MINUTES OF THE LAST ANNUAL MEETING - 29 September, 1985

The chairman directed the attention of the general assembly to the minutes of the previous annual meeting (circulated April, 1986). The Chairman called for any errors or omissions to the minutes of the 29 September, 1985 annual meeting. There being none reported, the Chairman called for a motion to approve the minutes.

MOTION (Dr. R. Patton/Dr. W. Croft)

"That the minutes of the Canadian Academy of Pediatric Dentistry Annual Meeting of September 29, 1985 be approved as circulated"

(carried)

86-03 BUSINESS ARISING FROM THE MINUTES

(1) Council on Specialties

The Chairman requested Dr. I.C. Bennett to comment on the status of the proposed changes that the Canadian Dental Association was contemplating with regard to the Specialties. Dr. Bennett reported the discussions were still occurring however there didn't appear to be any urgency nor rush to reach a quick resolution. He speculated that it would be further discussed during the Board of Governor's meeting in Halifax, this weekend. Dr. Bennett predicted that it would not be finalized but rather further direction would be given to the CDA Committee reviewing it. In response to a question, Dr. Bennett presented background information about the informal meeting of the Specialties which occurred with the President of CDA before the CDA annual meeting. This was seen to not work very well. Concern was raised about the poor communications which existed between the Specialty Organizations within CDA. A proposal was made that, instead

of having informal meetings with the President of CDA, a Council of Specialties be created. Representatives from each Specialty association would form a Council to deal with Specialty business as it related to CDA. This would improve communications and would get things done.

The chairman mentioned that CDA wanted to set up a rule that the Specialty meetings should occur in conjunction with the annual CDA. This had been discussed for at least the last seven years and nothing was resolved.

(11) Re-designation of Paedodontics to Pediatric Dentistry (name change)

The chairman asked the Secretary/Treasurer to report on the status of informing those identified in the motion of the name change of the Specialty from Paedodontics to Pediatric Dentistry. The Secretary/Treasurer informed the General Assembly that copies of the approved motion along with a proposal, which was being presented to the Board of Governors CDA at the Board meeting, along with a letter requesting their consideration and action were sent to the Dental Educational Institution, Provincial Dental Boards, Provincial Dental Association and the Royal College of Dentistry. As well, the International Association of Dentistry for Children and the American Academy of Pediatric Dentistry were informed. Some responses had been received stating that our recommendation would be considered or that the name change has already taken place. The chairman suggested that one member in each province should be contacted to follow-up and to monitor if the change of name designation had occurred.

86-04 SECRETARY/TREASURER'S REPORT

For ease of presentation, the Secretary/Treasurer separated the report into two individual units. The Secretary's report consisted of presenting to the General Assembly a verbal report of the activities which had been conducted by the Secretary/Treasurer on behalf of the membership. Change over of secretarial office occurred in December, 1985. An advance notice for the 7th congress was sent out. New letter head to reflect the name redesignation on the Academy stationery and membership application forms was designed and printed. Two newsletters, dues notices, dues receipts and a membership roster were prepared and sent out in two separate mailings. Letters notifying all those referred to in the motion for name redesignation were sent out. Notification of the new slate of officers was sent to the Executive Director of Canadian Dental Association. An editorial commentary along with a photograph of the President describing the activities of the Academy were sent to the Editor of the Journal of the Canadian Dental Association. Unfortunately, this was not printed in the Journal. Correspondence was also sent to the Academy American of Pediatric Dentistry. A very positive response re-affirming the willingness to work toward establishing good communication between the two Academy's was received from the current Executive Director, Dr. John Bogert. Correspondence along with the annual membership dues assessment was sent to Dr. Brook, Secretary/Treasurer, International Association of Dentistry for Children. Other routine correspondence

which had been received, was handled by the secretary on behalf of the academy. Membership applications along with an invitation to join the Academy had been forwarded along to new Pediatric Dentists. As of the first of August, no responses to the invitations had been received.

The Secretary/Treasurer concluded his secretary's report to the General Assembly by outlining some of the activities being planned for the next year. Newsletters would be sent in December and in March. The membership directory would be expanded to include a list of past executives, Honorary members, life members, and a copy of the constitution. Dues notices for 1987 would be sent in the December mail out and letters would be sent to all Provincial Registrars requesting a list of registered Pediatric Dental Specialist in that province. During the discussion of the report it was suggested that telephone numbers and addresses of other practice locations be included in the membership roster.

Prior to presenting the Treasurer's Report the Secretary/Treasurer informed the General Assembly that the financial statement circulated at the meeting (Appendix II) was an unaudited statement. The Secretary/Treasurer made reference to the custom in the Academy of presenting unaudited financial statements and recommended that in future this statement should be audited or reviewed either by an accounting firm or by members of the Academy who were not on the executive nor the standing committees of the Academy. The treasurer's report using the financial statement as a guide was presented for the period when the funds were transferred on 14 February, 1986 to 8 August, 1986. Following discussion of the financial statement, the following motion was made

MOTION: (Dr. B. Cuzak/Dr. A. Dungy)
"that the report of the Secretary/Treasurer be approved"
(carried)

86-05

MEMBERSHIP REPORT

The Secretary/Treasurer presented the membership report (Appendix III) as circulated to the General Assembly. As of 8 August, 1986 total membership in the Academy was one hundred and fifteen. Seventy-nine members had paid the 1986 dues and returned their registration forms before 8 August, 1986. Thirty-six members had not responded. The members who had not paid their 1986 dues were identified according to a list arranged according to the Province in which they were located.

The Executive Committee received applications for membership from Dr. Rosamund Harrison, Halifax, Nova Scotia and Dr. Oliver Osuji, Toronto, Ontario. The Executive Council reviewed the qualifications of the applicants and recommended that Dr. Harrison and Dr. Osuji be nominated as active members of the Canadian Academy of Pediatric Dentistry. The General Assembly was told that Dr. Joy Richman had received specialty status in the Province of British Columbia and qualified for Active Member classification. The chairman asked the General Assembly if there were any others who would qualify for membership in the Academy. Hearing none, the chairman called for the following motion:

MOTION: (Dr. A. Dungy/Dr. I. Bennett)
"That Dr. R. Harrison, Dr. J. Richman and Dr. O. Osuji
be elected as active members to the Canadian Academy of
Pediatric Dentistry."
(carried)

86-06

REPORTS

(i) International Association of Dental for Children - Congress Meeting

Dr. Pulver reported that he met with the Congress Executive of the I.A.D.C. in Zurich, Switzerland. He presented a report on the progress of plans and arrangements for the 11th I.A.D.C. Congress in Toronto in June 1987. The general consensus at the meeting was that the 11th congress in Toronto would be well attended with good representation from many countries. He read a letter which he presented at the congress meeting and a copy of which he had sent to the Editor of the Journal of the International Association of Dentistry for Children. The letter was an invitation to everyone to attend the 11th congress. It contained information about Toronto, Ontario and Canada. The Scientific program and associated activities were also outlined in the letter. Dr. Pulver concluded by stating that the Congress Committee appeared pleased and excited about the progress of the 11th Congress Organizing Committee in planning and arranging for this significant event in 1987.

(ii) Congress of the International Association of Dentistry for the Handicapped

Dr. Pulver reported that he attended the meeting of the International Association of Dentistry for the Handicapped in Berger, Norway. He informed the General assembly that on behalf of the 11th Congress Organizing Committee he made a presentation concerning the 11th Congress and extended an invitation for everyone to attend. There were a number of people from all over the world at the meeting and a lot of interest was expressed in attending the IADC 11th Congress in Toronto. Dr. Pulver reminded the General Assembly that a member of the Academy, Dr. Norm Levine was President of the International Association of Dentistry for the Handicapped.

(iii) Specialty Section Meeting - Canadian Dental Association

The chairman asked Dr. Dungy to comment on the meeting of Representatives of the Specialty Sections which he attended in Ottawa. Dr. Dungy reported that the concept of the Council of Specialties was accepted and that a motion which was presented by several General Dentists was defeated. The intend of the motion was to create a College of General Practice as part of the Specialty Sections. Dr. Dungy cautioned that even though the motion had been defeated that the motion could be re-introduced at a future meeting, that whoever represented Pediatric Dentistry should be ever mindful of its re-introduction and vote against it. The chairman supported the need for this Specialty to always be represented at meetings of this nature.

(iv) 11th Congress - IADC Meeting in Toronto, 1987

Dr. Pulver reviewed the current situation of the 11th Congress with regard to the planning and arrangements for the Congress. The activities of the 11th congress organizing committee were presented. He referred to the high quality abstracts of the scientific papers and presentations which had been received. Dr. Pulver informed the General assembly that it was still possible for members of the Academy to present twenty minute papers to the Congress. One only had to submit a request to Dr. Dungy who would send an application and abstract form to any one wishing to make a presentation. Dr. Pulver strongly urged and encouraged all Academy members to make every effort to attend the 11th Congress in Toronto June 7-11, 1987. As a matter of interest a request had been received from a Japanese travel agent representing one hundred and twenty-three Japanese Dentists for registration information to the 11th Congress.

Dr. Pulver presented, in detail, the scientific and social program to the General Assembly. He assured the members that the registration, accomodations and program information would soon be sent to everyone. The question of the registration fee for members of the academy was raised. Dr. Pulver reminded the General Assembly that fifty dollars of each members annual membership dues for the last three years was the academy's financial commitment to the 11th congress. This was done on the understanding that this contribution would be applied to the registration fee. After members paid their full 1987 membership dues it would result in a total of four payments, equalling two hundred dollars credit toward the registration. This would be applied to the four hundred dollar advanced registration fee and would leave a balance of two hundred dollars. Dr. Pulver hastened to add that for members who had not paid the full amount through dues, a portion equal to what they had paid in dues would be applied toward the registration. In response to a question about registering at the Congress, Dr. Pulver stated if one registered at the Congress the late registration fee would be four hundred and seventy-five dollars. A list of members with the amount paid in dues toward the registration would be available at the registration desk informing them of the balance owing on the registration fee. Dr. Pulver hoped that through the minutes this information concerning the 11th congress and registration fees would be communicated to all members of the Academy. Further discussion following Dr. Pulver's report.

86-07

DR. SAMUEL D. HARRIS FUND

The chairman presented background information on Dr. Samuel Harris and his influence and involvement with Pediatric Dentistry, nationally and internationally. Dr. Harris established a Foundation for the purpose of distribution of funds for the improvement of Pediatric Dentistry. Among the recipients of the funds were the International Association of Dentistry for Children, which received fifty thousand dollars and the Canadian Academy of Pediatric Dentistry which received a cheque for two thousand dollars (U.S. funds.) A committee consisting of Dr. Art Wood, Dr. Norm Levine and Dr. Pulver was struck to meet and discuss the establishment of a Dr. Samuel Harris fund. The intent of

this fund was to establish a source which anyone could add to through donations and have the fund grow within the Academy. The Academy would be responsible for determining the purpose for which the fund would be used and for its administration. The Secretary/Treasurer purchased a GIC for one year for \$2,743.40 (Canadian) with the initial cheque as shown on the Financial statement. (Appendix II)

The chairman referred to the IADC meeting held at Zinick which considered the distribution of funds received from the Foundation. A letter, signed by all members of the Board of Directors IADC, was read to the General Assembly. It acknowledged, most graciously, the generosity of Dr. Harris and informed him that it would be used to provide funds to member societies throughout the world to establish their own national foundations to promote Pediatric Dentistry. It would also be used to establish a Samuel Harris Lecture at each International Congress, where a young scientist from a developing country could make a presentation. The Board of Directors, IADC expressed the desire to bestow a suitable honour on Dr. Harris at the 11th congress in Toronto. Dr. Pulver recommended that the Academy also recognize Dr. Harris' contribution by making him an Honorary member of the Canadian Academy of Pediatric Dentistry, as outlined in the constitution.

The chairman said that the members of committee would continue to meet with Dr. Harris and encourage him to attend the 11th Congress to personally receive the honours. Dr. Pulver requested members of the Academy to submit suggestions to the committee how best the fund could be used to improve Pediatric Dentistry in Canada. He did not foresee the fund being used to help individuals set up a practice but rather for a more general benefit for all members. Discussion followed the chairman's report.

86-08 CORRESPONDENCE

The Secretary/Treasurer informed the General Assembly that of all the correspondence which was received and dealt with by the office, only one item would be of general interest. A request was received from the CDA on the Hospital and Institutional Services for the Academy to answer a questionnaire concerning the Canadian Health Act. The information would be used to plan actions that the CDA would take. The Executive Committee agreed that Dr. Dungy, as a member of the Hospital Accreditation system would be the most suitable person to respond to it.

The other item was the CDA request for the Academy to review the proposal for restructure of the Specialty Representation on CDA into a Council of Specialties. Dr. Bennett and Dr. Dungy had reported previously on this item.

86-09 NEW BUSINESS

(1) Dues Increase

The chairman commented on the current annual dues structure by stating that after the 1987 assessment, the dues level would revert to the

the credibility of a Specialty to the CDA and public was best shown by the number of members who were fellow certified in that Specialty.

86-10 OTHER BUSINESS

Dr. Bennett observed there was insufficient time scheduled in the program to conduct the Annual General Meeting. This was seen to be a long standing problem with the annual meetings. The breakfast meeting arrangement was not satisfactory as it did not allow for sufficient and in depth discussion. Dr. Bennett recommended that the Executive Committee consider times other than prior to the scientific presentations. The chairman agreed to investigate other times in which to schedule the annual general meetings.

86-11 RECOGNITION OF THE 7TH CONGRESS ORGANIZING COMMITTEE

The chairman expressed the appreciation of the General Assembly to members of the 7th congress Organizing Committee - Dr. Bob Patton, overall coordinator, Dr. Sam Cheung and Dr. Tim Tam. He noted the fine organization of the 7th congress, the assistance offered to those who wished to see Expo 86, the tremendous hospitality shown on the west coast and the hard work done on behalf of the academy. The general assembly supported the comments of the chairman with applause. Dr. Patton on behalf of the organizing committee, accepted the appreciation and thanked everyone for coming to Vancouver and being part of the 7th Congress and Expo 86. The Secretary/Treasurer recommended that the recognition and contribution of the 7th Congress Organizing Committee be recorded in the minutes. He further noted that the Committee totally organized and financially self-supported the congress through their own efforts, initiative, and planning.

86-12 ELECTION OF OFFICERS

In keeping with the terms of office as established by the Constitution, the President - Dr. Frank Pulver, and President Elect - Dr. Arlie Dungy had one more year to serve in office. The Secretary/Treasurer - Dr. Peter Pronych had completed the specified one year term. The Chairman presented the nominations of Dr. Peter Pronych for Secretary/Treasurer for 1986/87 and called for nominations from the floor. Receiving none, the chairman called for a motion:

MOTION: (Dr. D. Kennedy/Dr. V. Chafekar)
"that Dr. Peter Pronych be elected as secretary/treasurer for
a term of one year - 1986/87"
(carried)

The Elective Offices for Academy - 1986/87 as elected by the General Assembly were:

Immediate Past President - Dr. Ian Bennett
President - Dr. Frank Pulver
President Elect - Dr. Arlie Dungy
Secretary/Treasurer - Dr. Peter Pronych

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

ACADÉMIE CANADIENNE DE DENTISTERIE PÉDIATRIQUE

A G E N D A

ANNUAL BUSINESS MEETING

Tuesday, August 19, 1986

Eight O'Clock in the Morning

GAGE TOWERS, UNIVERSITY OF BRITISH COLUMBIA

1. Call to Order - President Frank Pulver
2. Minutes of Last Meeting - Sunday, September 29, 1985
3. Business arising from Minutes
4. Secretary/Treasurer's Report
5. Membership Report
6. Reports (a) IADC - Congress Executive Meeting at Zurich
 (b) Congress of the International Association of
 Dentistry for the Handicapped Meeting at Bergen
 (c) Canadian Dental Association - Specialty Section Meeting
 (d) 11th Congress - IADC Meeting in Toronto, 1987
7. Dr. Samuel D. Harris Fund
8. Correspondence
9. New Business (a) Dues increase
 (b) IADC Journal and Supporting Contribution
 (c) Honorary Membership
 (d) Recommendations for Adjustments/Changes to
 Specialty Examination Guidelines (as proposed
 by Dr. Kennedy)
10. Other Business
11. Recognition of 7th Canadian Congress Committee
12. Election of Officers
13. Next Meeting
14. Adjournment

Dr. Peter Pronych
Secretary-Treasurer

PMP/bj1

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

ACADÉMIE CANADIENNE DE DENTISTERIE PÉDIATRIQUE

1986 MEMBERSHIP REPORT
(as of August 8, 1986)

	<u>Total Members</u>	<u>Paid</u>	<u>Not Paid</u>	<u>Applicants</u>
ALBERTA	13	9	4	-
BRITISH COLUMBIA	19	10	9	-
MANITOBA	6	5	1	-
NOVA SCOTIA	6	5	1	(1)
ONTARIO	50	36	14	(1)
QUEBEC	17	12	5	-
SASKATCHEWAN	1	1	0	-
UNITED STATES	2	0	2	-
ENGLAND	1	1	0	-
TOTAL	115	79	36	(2)

MEMBERS NOT PAID AS OF AUGUST 8, 1986

ALBERTA: Derbyshire, Robertson, Simpson, Chafekar

BRITISH COLUMBIA: Ng, Croft, Irani, Pang, Chiang, Hyde, Jinks, Tam, Ruzicka

MANITOBA: Cross

NOVA SCOTIA: Cunningham

ONTARIO: Morley, Maltz, Scott, Young, Wood, King, Wright, Semenuk, Dungy, Anderson,
Denyar, Gellar, Peltoniemi, Rubinoff

QUEBEC: Albert, Dixter, Dundass, Perreault, Erlick

UNITED STATES: Rapp, Duperon

Prepared by
Dr. P. M. Pronych
Secretary-Treasurer

PMP/bj1

PAYMENT OF ANNUAL DUES - CANADIAN ACADEMY OF PEDIATRIC DENTISTRY
1987

PLEASE REMIT: \$80.00 (no later than 30 April, 1987)

NAME OF PEDIATRIC DENTIST

PRIMARY ADDRESS

.....POSTAL CODE

OTHER ADDRESS

.....POSTAL CODE

TELEPHONE NUMBERS ()-....., ()-.....

RETURN TO: Dr. P.M. Pronych, SECRETARY-TREASURER
366 Francklyn Street
Halifax, Nova Scotia
B3H 1A7

FOR MEMBERSHIP ROSTER INFORMATION

1. Area of involvement in Pediatric Dentistry:

☐ private practice ☐ % ☐ associate ☐ solo ☐ full-time ☐ part-time

☐ university based ____% didactic teaching ____% clinical teaching ____%
research ____% service ____%
other: _____

☐ hospital based % teaching % service %

2. Year of certification 19

FOR EXECUTIVE'S INFORMATION

1. What scientific topic(s) should be presented at the next Canadian Congress of the Canadian Academy of Pediatric Dentistry - 1988? (order of priority)

- 1.
- 2.
- 3.
- 4.

2. Suggestions to the Executive Committee (please use reverse side)

THANK YOU / PMP

CANADIAN ASSOCIATION OF ORTHODONTISTS

REPORT TO THE 1987 INTERIM CDA BOARD OF GOVERNORS

Items for Information - Not Requiring Board Action

The Canadian Association of Orthodontists held its Annual Meeting and Scientific Sessions in Halifax, August 13-16, 1986. Invited scientific session speakers were Dr. Robert Vanarsdall, Lorne Rozovsky, Q.C., and Martin Shulman. There were a total of 153 participants including orthodontists, spouses, auxiliaries and exhibitors. The President of the American Association of Orthodontists, Dr. Eugene Blair, attended the meeting and addressed the members. The following is a summary of the topics of discussion at the Annual Meeting:

1. The Association has a total of 413 members. Life members Drs. W. McColeman, W. McComb, B. Morrow, M. Rudisaile and T. Wachna were inducted and eleven members were approved.

The following Executive was elected:

President	Dr. Oleg S. Kopytov
Past President	Dr. Morley Bernstein
President Elect	Dr. Wayne Barro
First Vice President	Dr. Richard Pass
Second Vice President	Dr. Yale Malkin
Secretary/Treasurer	Dr. Henri Marion
Administrator	Ms. Catherine Anderson Brown

2. The Association approved a new Constitution and Logo.
3. Future Annual Meeting cities were approved.

1987	Toronto	September 17-19
1988	Edmonton	August 19-21
1989	Vancouver	September

The Association still believes that annual meetings should be scheduled in conjunction with CDA Annual conventions. However, due to our exclusion from Halifax meeting and the uncertainties of the Quebec city meeting (rescheduled for Montreal 1987), the Canadian Association of Orthodontists has no alternative but to independently schedule its annual meetings. We believe this to be an unnecessary division in Canadian dentistry and especially between general practitioners and specialists. The G.W. Grieve Memorial Lecture may be financially impossible to present without CAO concurrent participation at CDA meetings.

CANADIAN ASSOCIATION OF ORTHODONTISTS

4. The Board of Directors has approved a recommendation of self-insured Direct Reimbursement dental care program as an alternate third party health care delivery. We encourage CDA's concerns for capitation dentistry and recommend that the Direct Reimbursement option should get more extensive publication and exposure to the general public.
5. The CAO Insurance Committee has recommended the CDSPI Dentist's Staff Insurance Package for orthodontists and their staff with the reservation that certain benefits available with other plans are not included. It was hoped that such benefits, eg., dental, optical and other extended health care, will soon be part of the CDSPI package.
6. The Board of Directors invited Mr. Lorne Rozovsky, Q.C., to discuss informed consent and requirements for long term orthodontic records retention. Since informed consent is a process not a form, no current forms were recommended to the membership. Similarly limitations for orthodontic records retention vary with different provincial governments making a national policy impossible to adopt.
7. Canadian Foundation for the Advancement of Orthodontics has sponsored a University of Toronto orthodontic graduate student exchange program with the University of California at San Francisco.
8. The Bi-annual CAO Newsletter continues to be an appreciated communications source for the Canadian orthodontist. Dr. Walter Pilutik, Editor, was commended on his efforts on behalf of the Association.
9. Appreciation was extended to the CDA Taxation Committee, and in particular Dr. Robert Hicks, Past President CAO and Taxation Committee Chairman, for removing the Federal Sales Tax on certain dental (orthodontic) materials.

The Canadian Association approves the formation of a Council on Dental Specialists within the CDA Council Structure. Recommendations on the draft terms of reference have been submitted to the CDA Roles and Responsibilities Committee.

CANADIAN ASSOCIATION OF ORTHODONTISTS

Montreal will host the American Association of Orthodontists (AAO) annual convention May 10-13, 1987. The CAO and AAO executives will hold their annual meetings during the convention. Dr. Frank E. Shamy, Past President of CAO, will be the General Sessions Chairman.

Respectfully submitted,

Oleg S. Kopytov, D.D.S., MSc.
President

ADOPTION OF REPORT

The report of the Canadian Association of Orthodontists received as information by the Board of Governors, with thanks.

**ANNUAL
MEETING
BOARD OF GOVERNORS
CANADIAN DENTAL ASSOCIATION**

OTTAWA, ONTARIO

SEPTEMBER 11-12

1987

CDA STAFF

K. Allen, Information Officer
S. Deziel, Executive Assistant
C. Metcalfe, Associate Editor
M. Vaughan, Librarian

B. Henderson, Director of Education
and Accreditation
J. Neal, Director of Administration
L. Teteruck, Director of Communications
S. Vial, Accountant

OBSERVERS

<u>NAME</u>	<u>AFFILIATION</u>
F.E. Archer	P.E.I. Dental Association
S. Bangham	College of Dental Surgeons of British Columbia
B. Barr	Council on Student Affairs
B.D. Barrett	P.E.I. Dental Association
K.C. Bentley	Continuing Education Committee
J. Blackmer	New Brunswick Department of Health
B.L. Bowden	Newfoundland Dental Board
J. Brookfield	Ontario Dental Association
K. Butler	Canadian Dental Services Insurance Plans
M.J. Cripton	Royal College of Dentists of Canada
M.N. Deyette	Canadian Forces Dental Services
H. Dick	National Dental Examining Board of Canada
S.B. Doshi	Newfoundland and Labrador - Dept. of Health
J. Dufour	Gouvernement du Québec
J. Forsythe	Canadian Fund for Dental Education
D. Gallagher	Canadian Dental Hygienists' Association
J.C. Gillies	Ontario Dental Association
D. Gutkin	Third Party Dental Plans Committee
G.A. Howard	College of Dental Surgeons of Saskatchewan
R.D. Jones	Newfoundland Dental Association
V. Jones	Alberta Dental Association
G. Kravis	National Dental Examining Board of Canada
P. Lamarche	Ordre des dentistes du Québec
D. Lovely	Student Governor-Elect
G. MacDonald	Newfoundland Dental Association
J.D. MacLean	Award Recipient
R. McIntyre	Manitoba Dental Association
W.A. Maillet	Nova Scotia Dental Association
B. Martinello	Alberta Dental Association
D. Mock	Canadian Academy for Oral Pathology
K. Montgomery	Royal College of Dentists of Canada
D. Montminy	CDSPI Director
G. Nikiforuk	Royal College of Dental Surgeons of Ontario
D. Pamenter	Nova Scotia Dental Association
G.H. Peacock	College of Dental Surgeons of British Columbia
D. Pike	Canadian Dental Assistants' Association
K.F. Pownall	Royal College of Dental Surgeons of Ontario

OBSERVERS

<u>NAME</u>	<u>AFFILIATION</u>
F. Reid	Canadian Fund for Dental Education
B. Rocky	College of Dental Surgeons of British Columbia
W.R. Rosebush	Membership Committee
R.R. Schiewe	CDSPI Director
E.G. Schroeter	New Brunswick Dental Society
S. Sgro	Membership Committee
K.R. Skinner	Manitoba Dental Association
J.G. Thompson	New Brunswick Dental Society
R. Thordarson	College of Dental Surgeons of British Columbia
E. Williams	Canadian Dental Hygienists' Association
C. Worobey	Canadian Dental Hygienists' Association
J.N. Wright	CDSPI Director
G.S. Zwicker	CDSPI

**CANADIAN DENTAL ASSOCIATION
BOARD OF GOVERNORS**

OFFICERS & OFFICIALS

Chairman of the Board of Governors
Secretary to the Board of Governors

N.A. Mancini
A.J. Neilson

EXECUTIVE COUNCIL

J.R. Robertson, President
R.J. Markey, President-Elect
B.W. Holmes, Past-President

E.F. Allison
J. Christie
G. Dubé

D.E. MacFarlane
J.W. Niedermayer
K.L. Roach

BOARD OF GOVERNORS

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G.R. Sandercock
B. Sigfstead

NEWFOUNDLAND

T. Gushue

PRINCE EDWARD ISLAND

R. Wenn

BRITISH COLUMBIA

S. Vanry
R. Smith
D.E. MacFarlane
P.H. Trester

NOVA SCOTIA

J. Christie

QUEBEC

G. Dubé
M. Blain

MANITOBA

L.S. Allen

ONTARIO

K.L. Roach
B. Glave
J.R. Brookfield
B.H. Dolansky
W.G. Leggett
R.M. Balfour

SASKATCHEWAN

J.W. Niedermayer

NEW BRUNSWICK

C.S. Leblanc

**CDN. FORCES DENTAL
SERVICES**

J.F. Begin

STUDENT REPRESENTATIVE

P. Zakarow

HEALTH & WELFARE

W.R. Bedford

VETERANS AFFAIRS

J.C. Tsafaroff

Recording Secretary: Mrs. S. Burton

COUNCIL/COMMITTEE CHAIRMEN

M. Jahjah (Convention)
G.H. Peacock (Constitution & By-Laws)
R.Y. Barolet (Dental Mat./Cons. Prod. Rec.)
A. Schwartz (Education & Accreditation)
G.R. Thordarson (Ethics)
A. Toeman (Health Care)
J.H. Gryfe (Hosp. & Inst. Serv.)

Y. Kamachi (Information Serv.)
J.E. Durran (Insurance & Inv.)
P.R. Crawford (Nomin., Awards & Trusts/Membership)
J. Hardie (Publications)
R. Turcotte (Salaried Dentists)
B. Barr (Student Affairs)
R.N. Hicks (Taxation)

PRESIDENT'S REMARKS
CDA ANNUAL BOARD OF GOVERNORS - OTTAWA
SEPTEMBER 11-12, 1987

I would like to express a sincere welcome to all, at this Annual meeting of the Board of Governors. We have a busy schedule for the next two days, and I would beg your indulgence of the time constraints in light of the heavy agenda.

I would like to make a few remarks, this being my last meeting as President. At this meeting, one is filled with excitement, apprehension and a little sadness. Excitement because we have so many exciting things going on, many, many important matters to be discussed, adopted or defeated at this particular meeting. A little apprehension, because as those who have been here for a few years know, you can never anticipate what to expect at these meetings, or from some of the people who attend. Sadness, because I leave the position of President, and sadness because there are some of our members who have fulfilled their mandate and will not be with us for future Board deliberations.

My wife Betty and I have had the opportunity to travel across this vast, beautiful country of ours. We established a lot of friendships, which will last us for a lifetime and for that, I thank you. To the people who are leaving the Board, I thank them for their efforts, for their undying commitment, their time away from home and the office. Your contributions to dentistry have gone past the general call of duty to your profession, and I am proud of all of you. I would like to thank all of the Governors for their support over the year. We may not always have seen eye to eye, or agreed on everything, but we all worked towards the common goal of the betterment of dentistry for Canadians and the country as a whole.

I turn over the reins of the Presidency this evening to Dr. Ron Markey. I know that you will give Dr. Markey the same support that you gave me this year, for which I am sincerely grateful. Thank you for having me as your President, and now let us proceed with two days of productive discussion.

EXECUTIVE

REPORT TO THE 1987 ANNUAL MEETING CDA BOARD OF GOVERNORS

Members: Dr. John R. Robertson, Chairman, Summerside
Dr. Ron J. Markey, Vancouver
Dr. Bradley W. Holmes, Kenora
Dr. Kevin L. Roach, Pembroke
Dr. Don MacFarlane, Vancouver
Dr. Edward F. Allison, Calgary
Dr. Gilles Dubé, Lachute
Dr. Jack W. Niedermayer, Regina
Dr. John Christie, Bedford

1. Council Meetings

Since the 1987 Interim Meeting of the Board of Governors, the Executive Council has met once, on June 26-27, 1987.

ITEMS REQUIRING BOARD ACTION

2. Appointment of CDA Auditors

RESOLVED:

87.62 THAT the firm of McCay, Duff and Company be appointed CDA auditors for the fiscal year 1987.

ADOPTED

3. CDSPI - Council on Insurance and Investment

To comply with Article XVI, Section 4 (h) of the CDA Constitution and By-Laws.

RESOLVED:

87.63 THAT the Board of Directors of CDSPI be appointed the CDA Council on Insurance and Investment for the calendar year 1988.

ADOPTED

4. FDI - National Treasurer

The term of the National Treasurer to the FDI requires annual renewal. Dr. Robert N. Hicks will complete his third one year term in October, 1987.

RESOLVED:

- 87.64 THAT Dr. Robert N. Hicks be appointed as the CDA National Treasurer to FDI effective October, 1987.

ADOPTED

5. Corporate Member and Licensing Body Fees

The establishment of the principle of a fee structure for corporate members and licensing bodies dates back to a special meeting of the Board of Governors held in March, 1975.

RESOLVED:

- 87.65 THAT the Council on Constitution and By-Laws be directed to present amendments to the By-Laws at the next meeting of the Board of Governors with regard to fees paid by Corporate Members and Licensing Bodies, delineating

- a) their intent and purpose
- b) their derivation and
- c) the timing of payment and penalties for non-payment.

ADOPTED

6. Geriatric Dentistry

Following the 1987 Interim Meeting of the Board, input was requested on CDA's role in Geriatric Dentistry as outlined in the appended correspondence. Response is incomplete at this time and this topic, including a situation analysis, will be reviewed at the Executive Council fall planning session. The Executive Council considered it necessary to appoint a CDA spokesperson on Geriatric Dentistry to address information needs directed to CDA in this area of ever increasing interest and concern.

APPENDIX A

RESOLVED:

- 87.66 THAT Dr. John R. Robertson be appointed the CDA spokesperson on Geriatric Dentistry.

ADOPTED

7. Term of Office - CDA President and Elected Officials

The recommended amendment contained in the report of the Council on Constitution and By-Laws concerning the Term of Office for the President and elected officials of CDA was reviewed by Executive Council. Action to delay the assumption of office by the President following the Annual Meeting of the Board is seen to be counter-productive.

RESOLVED:

87.67 THAT motion # 87.4 quoted hereunder be rescinded.

"87.4 THAT regardless of the date of the Annual Meeting of the CDA Board of Governors at which elections of officers take place, the term of office for the President be from October 1 to September 30 of the following year;

THAT all elected officers, including members of Executive Council, assume and continue to hold office from October 1 to September 30 of the following year;

THAT this term of office be extended to all members of CDA Councils and Committees; and,

THAT the above motions be referred to the Council on Constitution and By-laws for the necessary By-law amendments.

ADOPTED"

ADOPTED

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

8. National Strategy - Dental Hygiene

Following direction received from the Board of Governors, the Executive Council has approved the formation of a study group to develop a CDA position on Dental Hygiene. Dr. Kevin L. Roach, Executive Council member from Ontario, and Dr. Donald E. MacFarlane, Executive Council member from British Columbia have been named as members of the study group. Mr. Brian Henderson, Director of Education and Accreditation will provide senior staff support.

9. Commission on Accreditation

Executive Council has reviewed references in the Report of the Council on Education and Accreditation, to the concept of a Commission on Accreditation. A discussion paper will be prepared on this topic for review by Executive Council at the fall planning session.

10. Professional Resource Utilization

A second meeting of the deans of Canadian Dental Faculties to consider dental professional resource utilization was held in Montreal on February 21, 1987.

The Chairman of CDA's Professional Resource Utilization Committee, Dr. Bradley W. Holmes and CDA Executive Director, Jardine Neilson attended a portion of the meeting for review and discussion of enrolment cutbacks.

Discussion is ongoing within the dental faculties on enrolment cutbacks for 1987-88 and 1988-89. The decision in this regard rests with the Senate of each university.

During discussion at the February 21, 1987 meeting the feasibility of a federal government commission to examine and plan future oral health needs for Canadians was introduced. The main thrust behind this suggestion was the necessity of an independent commission if study led to a recommendation on the closure of a school. An outline of the terms of reference for the proposed Commission has recently been received from Dr. George Beagrie. The Executive Council has expressed extreme concern with several items outlined in the terms of reference, in that they fall within the jurisdiction of the profession.

Further discussion with the deans is anticipated at the time of the CDA Teaching Conference this fall. Advice is being sought on the feasibility of an epidemiological study to address the perceived lack of such data in the R.K. House Reports.

11. Roles and Responsibilities

The review of the structure of CDA Councils and Committees as they relate to the definitions approved at the last meeting of the Board is ongoing, with a full report and recommendations anticipated at the fall planning session. The terms of reference for Executive Liaisons is also under review, and any recommended changes will be presented at a future meeting of the Board.

12. Order of Dentists of Quebec

Dr. Marc Boucher, President of the Order of Dentists of Quebec has written to CDA President, Dr. Robertson reiterating comments made before the Board of Governors at the meeting last April.

Comments made concerning the payment of the licensing body fees through the QDSA are not acceptable to CDA, nor have they been discussed with the QDSA.

It is hoped that the near future will provide an opportunity for discussion between the CDA and the ODQ.

Membership statistics indicate a large number of dentists in Quebec, (some four hundred), who are CDA members, and who are not represented at the level of the CDA Board, as they are not members of the QDSA. The Membership Committee has been asked to review this matter.

APPENDIX B

13. Committee on Salaried Dentists

A letter received from Dr. Robert Turcotte, Chairman of the Committee on Salaried Dentists on the future role and activities of his Committee is appended. The Executive Council has endorsed option (b) as outlined by Dr. Turcotte. Reference to the future activities of the Salaried Dentists Committee is contained in the Management Committee Report.

APPENDIX C

14. Canadian Dental Foundation

Correspondence has been received from Dr. Fred Reid, Chairman of the Canadian Fund for Dental Education expressing concern on the formation of the Canadian Dental Foundation. A meeting will be held with Drs. Reid and Ramage of the CFDE at the time of the September Board to clarify CDA's objectives in this area. The Report of the Taxation Committee contains recommendations for further action regarding the Canadian Dental Foundation.

APPENDIX D

15. Management of the Life Plan Surplus

In keeping with the responsibility outlined in the Participation Agreement with regard to the management of the Life Plan Surplus, the Executive Council has reviewed recommendations from the Council on Insurance and Investment. The comments of Executive Council are

contained in the Insurance and Investment report and include recommendations for earmarking an additional one million dollars for conditional distribution, and an amendment to the 1987 Participation Agreements.

16. CDA - RSP Financial Statements to May 31, 1987

Financial Statements for the CDA - RSP were reviewed and approved by Executive Council. This statement was approved prior to the Annual Meeting of the Board of Governors at the request of CDSPI in order to allow for production of an Annual Report by the end of July, 1987.

APPENDIX E

17. Distinguished Service Award

Executive Council wishes to announce that the Distinguished Service Award has been granted to Dr. James Douglas McLean of Bedford, Nova Scotia, for his service to the dental profession at both the provincial and national level.

APPENDIX F

18. Honorary Membership

The annual nominations for Honorary Membership were reviewed by Executive Council.

Executive Council is most pleased to announce that Dr. William R. Thompson of Trenton, Ontario has been awarded Honorary Membership in the Canadian Dental Association.

APPENDIX F

19. Canadian Dental Research Foundation

On recommendation of the Council on Dental Materials and Devices, Executive Council approved the awarding of the Canadian Dental Research Foundation Award to Dr. Leonard Chumak for his paper on "An In Vitro Investigation of Lingual Bonding". Dr. Chumak's research for his paper was conducted at the University of Western Ontario, and the Institutional Trophy has been awarded to the Faculty of Dentistry at that institution.

20. Life and Supporting Membership

Applications for Life and Supporting Memberships, as appended, were reviewed and approved by the Executive Council.

APPENDIX G

21. President's Activities

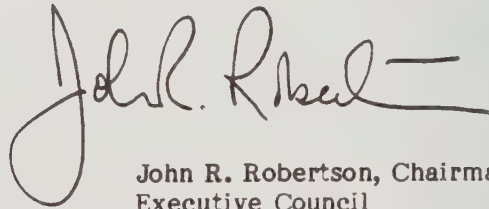
The schedule of activities of the President during his term in office is appended for information.

APPENDIX H

22. Council and Committee Reports

Executive Council has reviewed Executive Committee and Council Reports as appended, and other matters requiring Board action follow therein.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "John R. Robertson", with a long horizontal stroke extending to the right.

John R. Robertson, Chairman
Executive Council

ADOPTION OF REPORT

The Board of Governors accepts the report of the Executive Council with appreciation.

MEMORANDUM

April 13, 1987

TO: Presidents and Chief Executive Officers,
Corporate Members
Licensing Bodies
Deans, Dental Faculties
President, ACFD

FROM: Jardine Neilson, Executive Director

SUBJECT: Geriatric Dentistry

At the 1986 Executive Council planning session, Geriatric Dentistry was identified as an area requiring examination in terms of CDA's present and future role. The Roles and Responsibilities Committee has made an initial review of this item, and the following recommendations of the Committee were approved by the Board of Governors at its recent Interim Meeting:

- (i) THAT geriatric dentistry be encouraged and enhanced within existing CDA Councils and Committees.
- (ii) THAT Council/Committee Chairpersons be directed by Executive Council to report on on-going activities in the area of geriatric dentistry outlining present plans/programs in this area and potential future activities. Reports should target the September meeting of the Board.
- (iii) THAT a CDA situation analysis be prepared, within the same timeframe, delineating CDA's objectives in this area.

.../2

- (iv) THAT corporate bodies, licensing authorities, ACFD, and dental faculties be requested to comment on CDA's role in geriatric dentistry.
- (v) THAT further action to identify a specific existing or newly created area within the CDA structure for geriatric dentistry be deferred, pending review of all information requested.

I am writing to request your input concerning part (iv) of the above resolution. Please feel free to make the scope of your comment as broad as you feel appropriate, including the provision of information on your current role or plans in this area, and how the national dental association would complement or assist in this regard.

Information has been requested of CDA Councils/Committees as outlined in part (ii) above, and the CDA situation analysis has been initiated. It is hoped that all information can be made available for review by the Executive Council at its Pre-Board Meeting in June. It would therefore be appreciated if your information were received by June 1, 1987.

Thank you for your assistance.

A handwritten signature in dark ink, appearing to read "J. G. H. Smith" or similar, with a horizontal line underneath.

c.c.: Executive Council

/msg

MEMORANDUM

April 13, 1987

TO: Council/Committee Chairpersons

FROM: Jardine Neilson, Executive Director

SUBJECT: Geriatric Dentistry

At the 1986 Executive Council planning session, Geriatric Dentistry was identified as an area requiring examination in terms of CDA's present and future role. The Roles and Responsibilities Committee has made an initial review of this item, and the following recommendations of the Committee were approved by the Board of Governors at its recent Interim Meeting:

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- (iv) THAT corporate bodies, licensing authorities, ACFD, and dental faculties be requested to comment on CDA's role in geriatric dentistry.

.../2

- 2 -

- (v) THAT further action to identify a specific existing or newly created area within the CDA structure for geriatric dentistry be deferred, pending review of all information requested.

I am writing to request input from your Council/Committee as identified in part (ii) of the above resolution, and would request that you place this item on the agenda for your next meeting. Your Council/Committee Report to the 1987 Annual Meeting of the Board of Governors should contain any information and/or recommendations you wish to put forth.

As you will note from the resolution, we will be requesting input from several sources on CDA's role in Geriatric Dentistry; the preparation of a situation analysis is underway.

It is anticipated that on completion of this review, clarity of CDA's role will have been achieved and present and future activities delineated.

A handwritten signature in dark ink, appearing to read "Rein", with a horizontal line underneath the name.

c.c.: Executive Council
CDA Directors

/msg

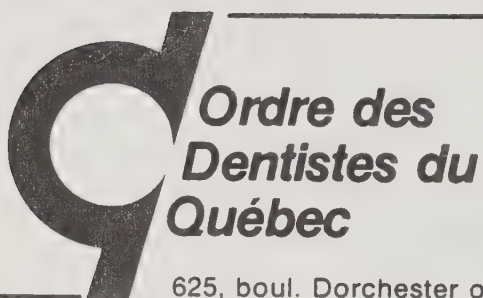
APPENDIX B

CANADIAN DENTAL ASSOCIATION1 9 8 7 MEMBERSHIP RETURNS AS AT JUNE 1987

	<u>ONTARIO</u>	<u>QUEBEC</u>	<u>OTHER VOLUNTARY</u>	<u>TOTAL</u>
<u>1 9 8 7</u>				
ACTIVE	2,660	912	40	3,612
AFFILIATE	39	495	9	543
SUPPORTING DENTIST	24	13	37	74
SUPPORTING NON-DENTIST	7	-	3	10
STUDENT	<u>81</u>	<u>49</u>	<u>37</u>	<u>167</u>
SUB-TOTAL	<u>2,811</u>	<u>1,469</u>	<u>126</u>	<u>4,406</u>
LIFE, HONORARY & PAST-PRESIDENTS	<u>361</u>	<u>164</u>	<u>-</u>	<u>525</u>
TOTAL	<u>3,172</u>	<u>1,633</u>	<u>126</u>	<u>4,931</u>

1 9 8 6 - PLEASE NOTE THESE FIGURES REPRESENT THE TOTAL RECEIVED FOR THE YEAR.

ACTIVE & AFFILIATE	2,670	1,457	11	4,138
SUPPORTING	13	7	11	31
STUDENT	<u>75</u>	<u>44</u>	<u>14</u>	<u>133</u>
SUB-TOTAL	<u>2,758</u>	<u>1,508</u>	<u>36</u>	<u>4,302</u>
LIFE, HONORARY & PAST-PRESIDENTS	<u>332</u>	<u>116</u>	<u>-</u>	<u>448</u>
TOTAL	<u>3,090</u>	<u>1,624</u>	<u>36</u>	<u>4,750</u>



625, boul. Dorchester ouest, 5e étage - Montréal, QC H3B 1R2 (514) 875-8511

Le 14 mai 1987

Docteur John Robertson
Association dentaire canadienne
1815 Alta Vista Drive
OTTAWA (Ontario)
K1G 3Y6

Monsieur le Président,

On dit, avec raison d'ailleurs, que les paroles s'envolent et que les écrits restent. N'ayant pas déposé de texte, lors de mon intervention du mois d'avril dernier, à la réunion intérimaire du Bureau des Gouverneurs, j'aimerais officialiser en quelque sorte, ce, qu'au nom de l'ODQ, j'ai dit à ce moment.

Il est à noter que, les arguments que j'ai fait valoir, à ce moment, étaient essentiellement basés sur les conclusions que nous avaient fait tenir le Comité chargé d'étudier la question ou, plutôt, les demandes que nous avons formulées.

L'étonnement passé, il fallait bien, vous en conviendrez, se rendre à l'évidence et constater que les règlements de l'ADC sont plus difficiles à modifier que la constitution canadienne. Une fois de plus, nous venions de nous rendre compte que les lois ou les règlements suivent toujours l'usage et que rarement elles le précèdent. En passant, disons que je trouve malheureux que, même si nous avons devant nous les signes avant-coureurs de graves problèmes, nous ne soyons pas en mesure de prendre les devants et de mettre en place, dès maintenant, les structures qui nous permettraient de profiter des talents disponibles où qu'ils soient. Les règlements seront peut-être modifiés un jour parce qu'on dit que nécessité fait loi. Ne sera-t-il pas trop tard?

EXECUTIVE DIRECTOR
RECEIVED

MAY 19 1987

.../2

Toujours est-il que de vos actuels règlements, le principe directeur qui prévaut et que vous nous faites valoir c'est que la représentation au Bureau des Gouverneurs est unique, unique dans le sens que les dentistes membres de l'ADC ne peuvent être représentés que par un seul membre corporatif et qui plus est, chaque membre de l'ADC ne peut être représenté plus d'une fois.

Cela veut dire que l'Association des chirurgiens dentistes du Québec est et demeure le seul représentant autorisé et qu'il n'est pas question que l'ODQ puisse être reconnu comme tel. Partant de là, l'ADC nous dit que si l'ODQ veut siéger au Bureau des Gouverneurs de l'ADC, celui-là devra négocier sa présence avec l'ACDQ.

L'ouverture possible que vous nous faites repose sur le deuxième volet du principe émis; les membres de l'ADC ne peuvent être représentés plus d'une fois. Chez vous, quelques petits futés, se sont interrogés pour savoir si tous les dentistes membres de l'ADC étaient effectivement représentés. Semble-t-il qu'il y en aurait quelques-uns dans le décor qui ne le seraient pas; l'ACDQ ne représentant que les dentistes membres de cette association, ce serait là l'opportunité pour l'ODQ de participer au Bureau des Gouverneurs. Cependant, il est à noter, que s'il devait y avoir ouverture dans ce sens c'est avec l'ACDQ que l'ODQ devrait négocier sa présence à l'ADC.

Beau joueur, nous avons accepté les conclusions de votre Comité. Remarquez que nous ne pouvions faire autrement puisque semble-t-il, il n'y avait pas d'appel possible.

Puisqu'il n'y avait pas de recours en quelque lieu, nous avons soumis la proposition suivante:

- 1- Nous reconnaissons la représentation unique de l'ACDQ;
- 2- Nous reconnaissons que les dentistes membres de l'ADC ne sont représentés qu'une fois;
- 3- Nous acceptons que 1 250 dentistes québécois sont ou seront membres de l'ADC;
- 4- Nous convenons qu'à 20,00 \$ par membre que quelqu'un devra souscrire 25 000 \$ à l'ADC et ce quelqu'un c'est l'ACDQ puisque c'est le membre corporatif;
- 5- Nous convenons de discuter de notre participation avec l'ACDQ;

6- S'il y a des frais, nous en discuterons également avec l'ACDQ puisque c'est "le" membre corporatif.

Voilà, monsieur le Président, l'essence de ce que nous avons fait valoir en réponse aux conclusions soumises par votre Comité.

J'ai de plus, dans une longue argumentation, répliqué à différentes questions posées. Mettant de côté, les raisons "légales", j'ai tenté de faire appel au sens des responsabilités de ceux et celles qui auront à mettre en place les mesures qui nous permettront de mieux préparer l'avenir.

Cet avenir, disons-le, sera à l'image de votre imagination, de vos efforts. Les solutions proposées auront d'autant plus de chance de connaître du succès si tous ceux qui ont la chance de vivre ou d'anticiper certains problèmes participent à l'élaboration de ces mêmes solutions.

L'ODQ, compte tenu des obligations qui sont siennes, a eu l'occasion d'acquérir une expérience certaine dont l'ADC, tous les dentistes et toute la population pourraient profiter.

Il me semble irresponsable qu'au nom de principes dont on pourrait discuter longtemps, on puisse se priver d'une expertise valable.

Ce qui devrait prévaloir d'abord et avant tout, c'est le bien de l'ensemble et si, comme se plaît à le dire un ancien président, la "mission" de l'ADC c'est de s'assurer que la population reçoive des soins de qualité et cela par des gens spécialement formés à cette fin, il est grand temps que vous fassiez quelque chose avant d'être dépassé par les événements.

Ce que le Québec veut, pour répondre à l'éternelle question, c'est de participer de plein droit au façonnement de l'avenir.

Espérant, monsieur le Président, que chez vous comme ailleurs, la bonne foi se présume, je vous prie de croire en la nôtre.

LE PRÉSIDENT,

Marc Boucher

MB/dl

Marc BOUCHER, d.d.s.

Ordre des dentistes du Québec

Dr. John Robertson
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear President;

One is right to say verba volent, scripta manent. As I did not submit a text with my intervention at the Interim Board of Governors Meeting last April, I would like to somewhat officialize what I said at that meeting on behalf of ODDQ.

It should be noted that my argumentation at that meeting was essentially based on the conclusions of the Study Committee on this issue, or rather on our request, which you conveyed to us at that time.

You will agree that once the surprise was over we had to face the fact and note that CDA by-laws are harder to change than the Canadian Constitution. Once more, we realized that usage always makes laws and by-laws, and the contrary is rare. By the way, I would say it is unfortunate that, with forerunners of serious problems, we are not in a position to take an initiative and set up right now the structures that would enable us to take advantage of available talents wherever they are. By-laws may be changed one day in the future because, as we say, necessity knows no law. But, then, would it not be too late?

The fact remains that the prevailing principle on which your actual by-laws are based and which you emphasize is that representation to the Board of Governors is unique, that is CDA member dentists are represented by one corporate member only, and in addition any CDA member may not be represented more than once.

This means that the Quebec Dental Surgeons Association is and remains the only one authorized representative, and the possibility that ODDQ be recognized also as a representative is out of question. As a consequence, CDA tells us that if ODDQ wants to sit on CDA Board of Governors it must negotiate with QDSA.

The possible ouvertures made by you are based on the second aspect of the principle; any CDA member may not be represented more than once. Some

wise guys in your group wondered whether all CDA member dentists are effectively represented or not. It seems that a few members are not represented. Because QDSA represents QDSA members only, this would provide ODQ an opportunity for sitting on the Board of Governors. However, it should be noted that should an overture in that direction be possible, it is with QDSA that the ODQ should negotiate its presence in CDA.

Being good losers, we accepted the conclusions of your committee. Please note that we could not do otherwise since there seemed to be no appeal possible.

And since there was no recourse whatsoever, we submitted the following proposal:

- 1 — We recognize the unique representation of QDSA;
- 2 — We recognize that CDA member dentists are represented once only;
- 3 — We accept that 1,250 Quebec dentists are or will be members of CDA;
- 4 — We agree that with a membership fee of \$20.00 per member someone will have to pay CDA \$25,000 and it will be QDSA as a corporate member;
- 5 — We agree to discuss our participation with QDSA;
- 6 — If there are costs to be paid, we will discuss this also with QDSA since it is "the" corporate member.

This is, Dear President, the substance of what we put forward in response to the conclusions submitted by your committee.

In addition, in a long argumentation, I answered various questions which were asked. Leaving "legal" reasons aside, I tried to appeal to the sense of responsibility of those who will have to make the policies required in order to prepare better for the future.

Let us say that this future will reflect our imagination and efforts. The solutions that will be put forward will have a better chance to succeed if all those experiencing or anticipating problems take part in the development of those solutions.

ODQ, taking into account its own obligations, has had the opportunity to acquire a definite experience that could benefit CDA, all dentists and the public as a whole.

In my view, to do without such a valuable expertise because of principles that could be discussed for a long time would appear irresponsible.

What should prevail above all is the overall well-being and if, as a former president enjoyed saying, CDA's "mission" is to ensure that the public receives high quality care and this by people who are especially trained for this purpose, it is about time that you do something before you are overtaken by events.

What Quebec wants, to answer the same question again, is to rightfully participate in building for the future.

I hope, Dear President, that we can rely on your good faith and that of others as well. You can rely on ours.

Yours Truly,

Marc Boucher, d.d.s.
President

ROBERT A. TURCOTTE, D.D.S.

910 McCAVOUR DRIVE
SAINT JOHN WEST, N. B.
E2M 4M3

May 4th, 1987.

Dr. John Robertson,
President,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario
K1G 3Y6

Dear John:

Upon being appointed by you as the Chairman of the Committee on Salaried Dentists and the subsequent filling of the vacancies on the committee, I requested from each of the members items of concern to their particular group that could be placed on an agenda for a tentative meeting. Only one member replied with items of concern that had previously been addressed by the Committee and I provided the member in question with some background material on these matters.

When the Committee was established by Executive Council in July 1983, one of its major roles defined at that time was to provide a forum for discussion of common interests and concerns of salaried dentists.

The Committee has not met since September 1985. Thus, one can conclude that there must not be any "burning issues" of concern unique to this particular segment of our profession.

Recently, I polled the members of the committee on the following options that could be recommended to Executive Council's June meeting:

(a) Disband the Committee

OR

(b) Maintain the Committee in place and periodically contact the members in the event concerns do arise.

In either case, CDA should continue to maintain and update its data bank on salaries and fringe benefits (ie. continuing education allowances, etc.) of salaried dentists from coast to coast to serve as a resource in negotiations for those concerned.

The committee was unanimous in endorsing option (b).

- 2 -

According to the terms of reference the committee is to meet annually and one committee member is rather insistent on this. However, I feel that it would be irresponsible on my part in these days of fiscal restraint to call a meeting just for the sake of having one..... I hope you'll agree.

I would appreciate your providing the Executive Council with this letter for their information and hopefully, their subsequent endorsement of our recommendation.

In closing, I would be remiss if I did not extend to you and the members of the Executive Council my sincerest thanks for naming me as a recipient of the CDA Certificate of Merit. It is an honor for me to be recognized by my peers for a small contribution to our profession. It was a privilege to serve on the Board of Governors and I hope to continue to contribute to organized dentistry on the council/committee level in the years to come.

Warmest regards,


Robert A. Turcotte, DDS
Chairman,
Committee on Salaried Dentists.

cc: Sandra Deziel



**CANADIAN FUND FOR DENTAL EDUCATION
FONDS CANADIEN POUR L'ENSEIGNEMENT DENTAIRE**

105 - 1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO K1G 3Y6
TELEPHONE: 613-731-0493

June 9, 1987

Dr. John Robertson
President
The Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear John,

The Board of Trustees wishes to express its concern over the ramifications to CFDE on the formation of the "Canadian Dental Foundation", and especially, the report to Executive Council on its aims, objectives and operations.

This interest centres around the following:

1. Apparent duplication of effort, since the formation of the Foundation reads like that of CFDE, only the names and numbers are different!
2. CDA has already created, appoints trustees to, and administers a charitable organization, the CFDE. It can, and does, donate money to the Fund and can direct, as do other donors, how it must be used.
3. The soliciting and receiving donations, gifts and requests for the Foundation places it in direct competition with CFDE.

Over the years, the major effort of the Trustees and staff of CFDE has been to raise funds. This has been a difficult task. It has now come to their attention that the Foundation has been soliciting donors to CFDE, making a difficult job more difficult, and eliciting considerable confusion from the donors.

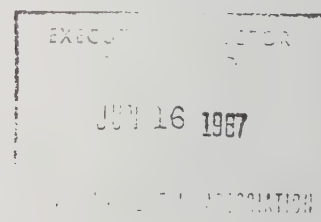
The Board of Trustees respectfully requests that you bring to the attention of the Executive Council their anxiety, and that the whole area of charitable organizations to serve the dental profession in Canada be reconsidered with, possibly, some input from CFDE.

Sincerely,


J. Fred Reid, D.D.S.
Chairman.

c.c. CFDE Trustees
Executive Secretary

JFR:ig



Clarke
Henning
& Co.

APPENDIX E

Partners

June 22, 1987

G. M. Fekir, C.A.
M. M. Hahn, C.A.
L. S. Hammond, C.A.
W. J. Henning, B.Com., C.A.
D. G. Hickman, C.A.
R. E. Hill, C.A.
S. J. Holton, B.Tech., C.A.
R. G. Hume, C.A.
D. R. Hunter, C.A.
A. C. Jamieson, C.A.
G. R. MacGregor, C.A.
L. F. McKee, C.A.
R. M. Poir, C.A.
V. M. Raja, C.A.
D. J. Reid, C.A.
C. J. Thompson, B.Com., C.A.
M. I. Zweng, C.A.

Ms. Elana Campbell, Marketing Co-ordinator,
Canadian Dental Service Plans Inc.,
2 Lansing Square, Suite 600,
Willowdale, Ontario
M2J 4Z3

Dear Elana:

CANADIAN DENTAL ASSOCIATION
- RETIREMENT SAVINGS PLAN (CDA-RSP)
YEAR ENDED MAY 31, 1987

We enclose herewith a copy of the annual financial statements of CDA-RSP for the year ended May 31, 1987 for distribution to the members of the CDA Executive Council for their meeting on June 23-25, 1987.

In addition, we enclose a copy of the financial statements and letter to Mr. Bertrand Picard of Pierrie Beaudry & Co.. As per my discussions with Peter Dennett, would you please 'fax' these statements to their office in order for them to do the french translation.

If you have any questions in connection with the above, please call.

Yours very truly,
CLARKE HENNING & CO.

/jjb

Vinay Raja
V.M. Raja, Partner

Encl.

c.c.: ✓ Mr. K.D. Butler,
Executive Vice-President

Member
International
Affiliation of
Independent
Accounting Firms

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

FINANCIAL STATEMENTS

Year ended May 31, 1987

Auditors' Report	Page 1
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Statement of Income	3
Statement of Changes in Net Assets	4
Investment Portfolios	5 to 10
Notes to Financial Statements	11 to 12

Clarke
Henning
& Co.

Chartered Accountants

44 Victoria Street
Toronto, Ontario
Canada M5C 1Y3
Tel: (416) 364-4421



AUDITORS' REPORT

TO THE BOARD OF GOVERNORS OF THE CANADIAN DENTAL ASSOCIATION
TRUSTEES FOR THE PARTICIPANTS IN THE CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

We have examined the statement of financial position and investment portfolios of the Canadian Dental Association Retirement Savings Plan as at May 31, 1987 and the statements of income and changes in net assets for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position and investment portfolios of the Plan as at May 31, 1987 and the results of its operations and the changes in its net assets for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Clarke Henning & Co.
CHARTERED ACCOUNTANTS

Toronto, Ontario
June 16, 1987

As at May 31, 1987

Approved on behalf of Canadian Dental Association:

Robert H., Governor

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

STATEMENT OF INCOME

Year ended May 31, 1987

	1987	1986
FIXED INCOME FUND		
Income		
Interest - Bonds	\$1,366,188	\$ 146,633
- Cash and short-term deposits	100,793	240,731
Profit on sale of investments	32,652	3,067,147
	<u>1,499,633</u>	<u>3,454,511</u>
Expenses		
Administration fees	115,400	72,431
Other	5,628	1,220
	<u>121,028</u>	<u>73,651</u>
Net Income	<u><u>1,378,605</u></u>	<u><u>3,380,860</u></u>
COMMON STOCK (EQUITY) FUND		
Income		
Dividends	573,204	559,045
Interest - Cash and short-term deposits	442,273	229,860
Profit on sale of investments	1,911,999	2,387,393
	<u>2,927,476</u>	<u>3,176,298</u>
Expenses		
Administration fees	192,086	111,789
Other	9,465	1,915
	<u>201,551</u>	<u>113,704</u>
Net Income	<u><u>\$ 2,725,925</u></u>	<u><u>3,062,594</u></u>
MONEY MARKET FUND		
Income		
Interest - Bonds	4,392	-
- Cash and short-term deposits	40,308	12,855
Profit on sale of investments	417,644	481,787
	<u>462,344</u>	<u>494,642</u>
Expenses		
Administration fees	68,051	58,122
Other	3,551	1,040
	<u>71,602</u>	<u>59,162</u>
Net Income	<u><u>390,742</u></u>	<u><u>435,480</u></u>
BALANCED FUND		
Income		
Interest - Cash and short-term deposits	1,462	9,681
Profit on sale of investments	4,560	3,570
	<u>6,022</u>	<u>13,251</u>
Expenses		
Administration fees	47,398	15,743
Other	2,332	247
	<u>49,730</u>	<u>15,990</u>
Net loss	<u><u>(43,708)</u></u>	<u><u>(2,739)</u></u>
GUARANTEED FUND		
Interest income	<u><u>\$ 118,892</u></u>	<u><u>\$ 134,779</u></u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

STATEMENT OF CHANGES IN NET ASSETS

Year ended May 31, 1987

	1987	1986
FIXED INCOME FUND		
Net deposits	\$ 2,697,701	\$ 2,483,276
Net income	1,378,605	3,380,860
Change in market value of investments	<u>95,590</u>	<u>(1,622,384)</u>
Increase in net assets	4,171,896	4,241,752
Net assets at beginning of year, at market value	16,447,732	12,205,980
Net assets at end of year, at market value	<u>20,619,628</u>	<u>16,447,732</u>
Unit value	<u>56.43377</u>	<u>51.83559</u>
COMMON STOCK (EQUITY) FUND		
Net deposits	4,140,101	2,727,938
Net income	2,725,925	3,062,594
Change in market value of investments	<u>2,813,541</u>	<u>2,136,818</u>
Increase in net assets	9,679,567	7,927,350
Net assets at beginning of year, at market value	27,309,745	19,382,395
Net assets at end of year, at market value	<u>36,989,312</u>	<u>27,309,745</u>
Unit value	<u>143.50393</u>	<u>120.17464</u>
MONEY MARKET FUND		
Net deposits (redemptions)	827,110	(1,332,083)
Net income	390,742	435,480
Change in market value of investments	<u>404,531</u>	<u>605,764</u>
Increase in net assets	1,622,383	(290,839)
Net assets at beginning of year, at market value	10,789,286	11,080,125
Net assets at end of year, at market value	<u>12,411,669</u>	<u>10,789,286</u>
Unit value	<u>37.46978</u>	<u>34.85591</u>
BALANCED FUND		
Net deposits	6,657,537	2,042,665
Net loss	(43,708)	(2,739)
Change in market value of investments	<u>771,860</u>	<u>559,400</u>
Increase in net assets	7,385,689	2,599,326
Net assets at beginning of year, at market value	4,860,024	2,260,698
Net assets at end of year, at market value	<u>12,245,713</u>	<u>4,860,024</u>
Unit value	<u>24.77387</u>	<u>22.14624</u>
GUARANTEED FUND		
Net deposits	488,805	711,101
Net income	<u>118,892</u>	<u>134,779</u>
Increase in net assets	607,697	845,880
Net assets at beginning of year	1,656,009	810,129
Net assets at end of year	<u>\$ 2,263,706</u>	<u>\$ 1,656,009</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

FIXED INCOME FUND

Units	No. of Units	Average Cost	Market Value
The Imperial Life Assurance Company of Canada Pooled Mortgage Fund Units	51,964	<u>\$ 2,052,747</u>	<u>\$ 3,274,374</u>
Bonds	Par Value		
Government of Canada			
September 1, 1987 - 14.25%	800,000	974,000	948,000
December 6, 1987 - 9.25%	550,000	553,795	551,375
December 15, 1989 - 11.25%	325,000	342,468	337,594
October 15, 1992 - 13.5%	300,000	357,000	347,625
October 1, 2001 - 9.5%	2,000,000	2,066,850	2,015,000
December 15, 2002 - 11.25%	550,000	625,900	610,500
March 1, 2005 - 12%	350,000	419,475	406,438
September 1, 2005 - 12.25%	850,000	1,036,150	1,001,938
June 1, 2008 - 10%	500,000	558,750	510,000
November 1, 1987 - coupon	58,500	50,386	56,306
May 1, 1988 - coupon	58,500	48,116	53,820
November 1, 1988 - coupon	58,500	45,852	51,480
May 1, 1989 - coupon	58,500	43,729	49,213
November 1, 1989 - coupon	58,500	41,681	46,581
May 1, 1990 - coupon	58,500	39,780	44,460
November 1, 1990 - coupon	58,500	37,879	42,193
May 1, 1991 - coupon	58,500	36,054	40,292
		<u>7,277,865</u>	<u>7,112,815</u>
Provincial Bonds			
Manitoba Municipal			
8.25% due March 31, 1995	550,000	548,075	545,875
Newfoundland Municipal Finance			
10.375% due May 3, 2000	650,000	646,750	646,425
Ontario			
7.75% due December 1, 1997	100,000	87,500	88,500
Ontario Hydro			
8.5% due May 1, 1997	1,750,000	1,758,750	1,627,500
Ontario Hydro			
9.25% due January 6, 2004	1,300,000	1,270,609	1,223,625
		<u>4,311,684</u>	<u>4,131,925</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

FIXED INCOME FUND - Continued

Bonds	Par Value	Average Cost	Market Value
Corporate Bonds			
Bank of Montreal Leasing 11.75% due December 15, 1988	400,000	\$ 414,000	\$ 409,500
Bank of Montreal Mortgage Corp. 10.84% due September 5, 1990	250,000	256,250	254,375
Bank of Montreal Mortgage Corp. 10.05% due July 15, 1993	300,000	303,540	296,625
Bank of Montreal Mortgage Corp. 9.70% due July 29, 1991	300,000	299,550	294,750
Bank of Montreal Mid Term B/A 9.75% due July 26, 1991	200,000	200,000	197,000
CIBC Mortgage Corp. 10.375% due June 18, 1990	250,000	252,200	251,562
Continental Bank Mortgage Corp. 11.00% due June 21, 1990	500,000	500,000	507,500
Royal Bank 11.67% due January 10, 1989	250,000	258,750	255,939
Royal Bank Mortgage 9.75% due October 6, 1991	1,500,000	1,498,125	1,475,625
Roymar Mortgage 12.25% due August 26, 1988	200,000	208,160	205,750
Traders Group 8.75% due May 1, 1993	100,000	88,750	90,375
		<u>4,279,325</u>	<u>4,239,001</u>
Total bonds		<u>\$15,868,874</u>	<u>\$15,483,739</u>

COMMON STOCK (EQUITY) FUND

Canadian Equities	No. of Shares		
Communications and Media			
Astral Bellevue Pathe Inc. Class A	40,000	242,000	430,000
Astral Bellevue Pathe Inc. Class B	8,900	90,856	101,238
CHUM Ltd. Class B	30,600	514,692	489,600
Shaw Cablesystems Ltd. Class B	33,000	561,000	726,000
Thompson Newspapers Class A	26,100	325,758	828,675
		<u>1,734,306</u>	<u>2,575,513</u>
Consumer Products			
C.C.L. Industries Inc. Class B	18,900	341,712	245,700
Corby Distilleries Ltd.	25,400	509,778	603,250
F.C.A. International Ltd.	27,900	523,757	460,350
Imasco Ltd.	17,000	516,085	573,750
M.D.S. Health Group Ltd. Class B	22,500	394,252	472,500
Nabisco Brands Ltd.	8,100	189,662	311,850
Nelson Holding International Pref. A	54,100	311,075	251,565
The Seagram Company Limited	7,000	635,880	654,500
		<u>3,422,201</u>	<u>3,573,465</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

COMMON STOCK (EQUITY) FUND - Continued

Canadian Equities	No. of Shares	Average Cost Market Value	
Financial Services			
Bank of Nova Scotia	21,800	\$ 312,729	\$ 392,400
Canadian Imperial Bank of Commerce	39,500	607,043	849,250
National Bank of Canada	48,400	647,400	689,700
Power Financial Corporation	24,400	333,975	536,800
Royal Bank of Canada	13,100	427,642	435,575
Toronto-Dominion Bank	31,403	334,988	887,135
Traders Group Ltd. Class A	18,800	433,716	1,052,800
		<u>3,097,493</u>	<u>4,843,660</u>
Golds			
Echo Bay Mines Limited	9,600	278,400	465,600
Lac Minerals Ltd.	9,400	407,213	415,950
Placer Developments Limited	28,800	374,400	633,600
		<u>1,060,013</u>	<u>1,515,150</u>
Industrial Products			
Derlan Industries Ltd.	46,600	500,950	652,400
GEAC Computer Con 9.00 Oct 1/95	300,000	300,000	96,000
Ipsco Inc.	7,423	99,758	74,230
Moore Corporation Ltd.	49,047	456,664	1,606,289
Northern Telecom Ltd.	22,600	551,891	598,900
		<u>1,909,263</u>	<u>3,027,819</u>
Management Companies			
Canadian Pacific Ltd.	56,800	996,577	1,320,600
Merchandising			
Computer Innovation Distribution Inc.	94,400	279,424	302,080
Metals and Minerals			
Alcan Aluminium Limited	18,450	614,951	678,038
Brunswick Mining & Smelting	27,000	273,047	432,000
Falconbridge Mines Ltd.	15,300	352,818	328,950
Falconbridge Mines Ltd. - Deferred rights	2,400	4,800	9,600
Noranda Mines Ltd. Pref. C	22,400	560,000	789,600
Teck Corporation Class B	11,400	271,245	340,575
Teck Corporation 7.25% Ser F Cum. Red. Conv. Pfd.	8,200	205,000	360,800
		<u>2,281,861</u>	<u>2,939,563</u>
Oil and Gas			
Norcen Energy Resources	48,800	674,583	1,177,300
Shell Canada Ltd. Class A	16,100	445,902	714,437
		<u>1,120,485</u>	<u>1,891,737</u>

- 7 -

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

COMMON STOCK (EQUITY) FUND - Continued

Canadian Equities	No. of Shares	Average Cost	Market Value
Paper and Forest Products			
British Columbia Forest Products Limited	32,900	\$ 606,413	\$ 625,100
Consolidated Bathurst S-A	29,800	301,499	547,575
		<u>907,912</u>	<u>1,172,675</u>
Pipelines			
Interprovincial Pipelines	15,000	414,000	725,625
Real Estate and Construction			
Bramalea Ltd.	13,800	241,134	338,100
Campeau Corporation Common New	9,500	171,000	346,750
Trizec Corporation Limited Class A	9,600	135,350	307,200
Trizec Corporation Limited Class B	18,450	272,405	608,850
		<u>819,889</u>	<u>1,600,900</u>
Transportation			
Laidlaw Transportation Ltd. Class A	96,750	100,897	2,043,844
Pacifoc Western Airline Corp.			
Conv. 7.625 due December 30, 1996	200,000	200,000	228,000
Pacific Western Airline Corp.	25,000	510,953	615,625
		<u>811,850</u>	<u>2,887,469</u>
Utilities			
Bell Canada Enterprises Ltd.	26,500	884,270	1,106,375
Transalta Utilities Corporation Class A	9,652	145,231	289,560
		<u>1,029,501</u>	<u>1,395,935</u>
Total Canadian Equities (90.14%)		<u><u>19,884,772</u></u>	<u><u>29,772,191</u></u>
United States Equities			
Basic Industries			
Amax Inc.	6,000	169,218	173,606
Dow Chemical Company	1,600	69,566	177,419
Ethyl Corporation	4,000	104,568	148,518
Fisher Scientific Group	187	-	3,190
Henley Group	3,000	86,231	101,354
Union Carbide Corporation	3,000	93,265	115,403
		<u>522,848</u>	<u>719,490</u>
Capital Goods			
Research - Cottrell	2,000	67,139	103,026
Westinghouse Electric Corporation	5,000	143,486	398,891
		<u>210,625</u>	<u>501,917</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

COMMON STOCK (EQUITY) FUND - Continued

United States Equities	No. of Shares	Average Cost	Market Value
Capital Goods - Technology			
Boeing Company	5,400	\$ 149,692	\$ 135,473
Lockheed Corporation	2,000	<u>211,820</u>	<u>326,940</u>
		361,512	462,413
Consumer Cyclical			
Western Auto Supply	2,000	35,287	28,767
Consumer Growth			
Johnson & Johnson	2,200	121,058	253,150
Merck & Company Inc.	800	47,892	169,524
Pepsico Inc.	2,100	30,363	98,343
R.J.R. Nabisco Inc.	1,000	<u>88,539</u>	<u>67,736</u>
		287,852	588,753
Credit Cyclical			
Bowater Inc.	2,000	96,479	100,350
Georgia Pacific Corporation	3,000	<u>133,293</u>	<u>169,592</u>
		229,772	269,942
Defensive Consumer Staples			
Anheuser Busch Cos. Inc.	2,000	70,037	89,646
Clorox Company	2,200	<u>76,668</u>	<u>158,586</u>
		146,705	248,232
Energy			
Royal Duche Petroleum	1,000	124,281	167,417
Financial			
American General Corporation	3,500	97,835	70,245
Federal National Mortgage Association	2,000	118,310	101,688
Firemans Fund Corp.	1,000	<u>50,019</u>	<u>48,335</u>
		462,344	220,268
Utilities			
Centerior Energy Ltd.	2,200	80,202	47,153
Total United States Equities (9.86%)		<u>2,265,248</u>	<u>3,254,352</u>
Total Common Stocks (100.00%)		<u>\$22,150,020</u>	<u>\$33,026,543</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1987

MONEY MARKET FUND

	Par Value	Average Cost	Market Value
Bank of Nova Scotia floating certified deposit - March 31, 1992	700,000	<u>\$ 700,000</u>	<u>\$ 698,250</u>

BALANCED FUND

	No. of Units		
The Imperial Life Assurance Company of Canada Pooled Diversified Fund Units	259,836	<u>\$10,366,510</u>	<u>\$12,175,608</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

NOTES TO FINANCIAL STATEMENTS

Year ended May 31, 1987

1. Summary of significant accounting policies

The financial statements have been prepared in accordance with accounting principles generally acceptable for pooled trust funds. A description of accounting policies of particular significance is as follows:

a) Investments

Investments are stated at market value on the following basis:

- (i) Stocks listed on a recognized stock exchange are valued at their closing sale prices.
- (ii) Bonds are valued at the average of bid and ask prices at May 31, 1987.
- (iii) Units of The Imperial Life Assurance Company of Canada are valued on the last business day of each week by dividing the total number of units of the Fund then outstanding into the net assets of the Fund, being the fair market value in Canadian funds of assets less liabilities as at the same date.

b) Valuation of units

Units are valued for the purposes of issue or redemption as at the close of business on the last business day of each week by dividing the total number of units of the Fund then outstanding into the net assets of the Fund, being the fair market value in Canadian funds of assets less liabilities as at the same date.

c) Income

Dividends are recognized as income on the ex-dividend date. Interest income is accrued at the stated rate of the debt security.

d) Contributions, transfers, terminations

All contributions, transfers and terminations made by the participants of the plan have been accounted for on an accrual basis.

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

NOTES TO FINANCIAL STATEMENTS

Year ended May 31, 1987

1. Summary of significant accounting policies - continued

e) Foreign currency translation

Accounts in foreign currencies have been translated into Canadian dollars as follows:

- (i) current assets and current liabilities at the exchange rate prevailing at the Balance Sheet date;
- (ii) purchases and sales of investments and revenue and expenses at the rate of exchange prevailing on the respective dates of such transactions.

Gains or losses resulting from the translation of foreign currencies are included in income.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

June 29, 1987

Dr. James Douglas McLean
54 Lake Drive
BEDFORD, Nova Scotia
B4A 1H9

Dear Dr. McLean:

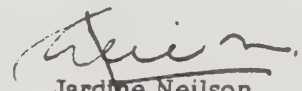
On behalf of the President and the Executive Council of the Canadian Dental Association, I wish to offer you sincere congratulations on being named as a recipient of the Canadian Dental Association Distinguished Service Award.

The Distinguished Service Award is conferred on those who have rendered outstanding service to the Association. It may also recognize outstanding contributions to the dental profession at the corporate, specialty society, council or committee level.

The presentation of your award will be made at a special luncheon honouring award recipients and past-presidents of the CDA. The luncheon has been scheduled in conjunction with the Annual Meeting of the CDA Board of Governors and will be held at the Four Seasons Hotel, Ottawa, on Friday, September 11, commencing at 12:30 p.m. It would give us great pleasure if you and your spouse or guest were able to attend the luncheon for personal presentation of your award. The CDA would be responsible for travel and accommodation expenses.

I look forward to hearing from you.

Sincerely yours,


Jardine Neilson
Executive Director

c.c.: Executive Council
Dr. Nick Mancini, Chairman - Board of Governors

/msg



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

June 29, 1987

Dr. William R. Thompson
R.R. #5
TRENTON, Ontario
K8V 5P8

Dear Bill:

On behalf of the President and the Executive Council of the Canadian Dental Association, I wish to offer you sincere congratulations on being named to Honorary Membership.

As you know, Honorary Membership is the Canadian Dental Association's highest award. It is conferred on persons who have made outstanding contributions to the art and science of dentistry, or to the dental profession at the provincial, national or international level.

The presentation of your award will be made at a special luncheon honouring award recipients and past-presidents of the CDA. The luncheon has been scheduled in conjunction with the Annual Meeting of the CDA Board of Governors and will be held at the Four Seasons Hotel, Ottawa, on Friday, September 11, commencing at 12:30 p.m. It would give us great pleasure if you and Doris were able to attend the luncheon for personal presentation of your award. The CDA would be responsible for travel and accommodation expenses.

I look forward to hearing from you.

Sincerely yours,


Jardine Nelson
Executive Director

c.c.: Executive Council
Dr. Nick Mancini, Chairman - Board of Governors

/msg

CANADIAN DENTAL ASSOCIATIONAPPLICATIONS FOR SUPPORTING MEMBER STATUS 1987

<u>NAME</u>	<u>PROVINCE</u>	<u>REASON</u>
KATE MACDONALD	N S	Non Dentist
DR P CASTONGUAY	N B	N B Associate
DR I FINEBERG	N B	N B Associate
DR A JOSHI	N B	N B Associate
DR G R GOODINE	N B	N B Associate
DR T HAYWOOD	N B	N B Associate
DR H V LISTINIK	N B	N B Associate
DR J LEVESQUE	N B	N B Associate
DR M MONNEY	N B	N B Associate
DR P ST ONGE	N B	N B Associate
DR IRVING D APPLEBY	ONT	Retired - Non-Licensed
DR MAURICE C COLE	ONT	Retired - Non-Licensed
DR W F COOK	ONT	Retired
DR R G ELLIS	ONT	Retired - Non-Licensed
DR WARREN R HILLIARD	ONT	Heart Surgery
DR G MCCAULEY	ONT	Retired - Non-Licensed
DR JOHN C MCCALOUR	ONT	Retired
DR GLENN O MCLAY	ONT	Fully Retired
DR OSAMA S E MICHAIL	ONT	Retired Permanently Disabled
DR LYONS C RINGROSE	ONT	Disabled
DR PETER A DOGEN	QUE	Retired
DR PATRICK LEAHY	QUE	Completely Retired
DR LOUIS EPSTEIN	B C	Retired - Non-Licensed
DR DON J FIETZ	B C	Non-Licensed
DR WILLIAM G HASTINGS	B C	Retired - Non-Licensed
DR NORI NISHIO	B C	Retired - Non-Licensed
DR W W SHORTILL	B C	Retired - Non-Licensed
DR DANIEL K L YIP	B C	Removed - Prosecuted
DR LORNE M GOLUB	USA	Not Licensed Canada
DR WILLIAM B GUSSOW	USA	Not Licensed Canada
DR M SZIKMAN	USA	Not Licensed Canada
DR MUNIR AHMAD	ARABIAN GULF	Not Licensed Canada
DR A P GARRETT	AUSTRALIA	Not Licensed Canada
DR ROBIN B DICKSON	GREAT BRITAIN	Not Licensed Canada
PROF A RUPRECHT	WEST GERMANY	Not Licensed Canada
DR PETER M FEURTADO	JAMAICA	Not Licensed Canada

CANADIAN DENTAL ASSOCIATION
APPLICATION FOR LIFE MEMBERS STATUS 1987

<u>NAME</u>	<u>PROVINCE</u>	<u>YEAR OF GRADUATION</u>
DR PAUL CORMIER	N B	1947
DR D SPELLER	MAN	1942
DR L FINKLE	USA	1934



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
 1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
 TELEPHONE (613) 523-1770

SCHEDULE

PRESIDENT - DR. JOHN R. ROBERTSON

1986

August 23	CDSPI Annual Meeting	Halifax	
August 25	Executive Council	Halifax	
Sept. 3	University of Toronto - Welcome (represented by Dr. Roach)	Toronto	
Sept. 5-7	Conf. Board of Canada	St. Andrews	
Sept. 12-14	Northern Ontario Convention	Timmins	
Sept. 17	Prov. Dental Directors Conference (represented by Dr. Markey)	Calgary	
Sept. 18	ADA/CDA Executive Meeting	Chicago	
Sept. 25	NSDA Student Night	Halifax	
Sept. 29	Meeting Premier PEI	Charlottetown	
Oct. 6-7	Canadian Medical Colleges	Toronto	
Oct. 8	Laval University	Quebec	
Oct. 9	University of Montreal	Montreal	
Oct. 17	ODA Special Meeting	Toronto	
Oct. 18-21	American Dental Convention	Miami	
Oct. 21	Toronto - All Societies Meeting (represented by Dr. Markey)	Toronto	
Oct. 22	CDSPI/CDA Management	Toronto	
Oct. 28	Management/Dr. Landry	Ottawa	*

Oct. 29-30	Management Committee	Mont Ste-Marie
Oct. 31-Nov.2	Executive Council	Mont Ste-Marie
Nov. 9-15	FDI Congress	Manila
Nov. 17	Welcome to the Profession McGill University (Represented by Mr. Neilson)	Montreal
Nov. 18	University of Toronto - Student Night (Represented by Mr. Neilson)	Toronto
Nov. 19	Univ. of Western Ont. - Student Night (Represented by Dr. Leggett)	London
Nov. 20	Winter Clinic (Represented by Dr. Markey)	Toronto
Nov. 21-22	ODA Board (Represented by Dr. Markey)	Toronto
Nov. 23-24	NDEB	Ottawa
Dec. 5	Licensing Bodies Conference	Toronto

1987

Jan. 14-18	Manitoba Dental Association	Winnipeg
Feb. 10	Call the President Day	Ottawa
Feb. 11-12	Management Committee	Ottawa
Feb. 13-14	Executive Council	Ottawa
March 26	Sherbrooke Society Meeting	Sherbrooke
March 27-28	Atlantic Provinces Dental Executive Committee	Halifax
April 2	DAP Reception	Ottawa
April 3-4	CDA Interim Meeting - Board of Gov.	Ottawa
April 3	Meeting CDA/CDHA	Ottawa
May 1-2	Annual General Meeting - Newfoundland Dental Association	St-John's

May 2	New Brunswick Annual Meeting	Fredericton
May 8-9	ODA Board	Toronto
May 10-12	ODA Convention	Toronto
May 24-28	CDA/ODQ Convention	Montreal
May 29	Luncheon - 1987 Graduating Class Faculty of Dentistry - U of T	Toronto
May 30	P.E.I. Annual Meeting	Summerside
June 11-13	Saskatchewan College Convention	North Battleford
June 17-18	House of Delegates Meeting - ACFD	Vancouver
June 18-21	College of Dental Surgeons of B.C. Convention/UBC 25th Anniversary	Vancouver
June 24-25	Management Committee	Ottawa
June 26-27	Executive Council	Ottawa
June 28-July 1	Conjoint Alberta Dental/Pacific Dental Federation Convention	Banff
Aug. 5-6	CFDS Grad Ceremonies	Borden
Aug. 28-29	Atlantic Provinces Meeting	T.B.C.
Sept. 2	Welcome to the Profession University of Toronto (Represented by Dr. Roach)	Toronto
Sept. 4-6	Northern Ontario Dental Society	North Bay
Sept. 10	Presidents and CEO's	Ottawa
Sept. 11-12	Annual Board	Ottawa

* Tentative

MANAGEMENT

REPORT TO THE 1987 ANNUAL MEETING CDA BOARD OF GOVERNORS

Members: Dr. John R. Robertson, Chairman
 Dr. Ron J. Markey, Vancouver
 Dr. Bradley W. Holmes, Kenora

1. Committee Meetings

Since the 1987 Interim Meeting of the Board of Governors, the Management Committee met once, on June 24-25, 1987.

ITEMS REQUIRING BOARD ACTION

2. 1988 Budget

Management Committee reviewed a preliminary proposal for the 1988 Budget. The objective of a surplus budget in 1988 was stressed and endorsed by the Executive Council.

In reviewing current priorities and the cost-effectiveness of CDA programs and activities, the following decisions were made:

- a) The Council on Ethics will be directed to structure their 1988 activities through utilization of conference calls and the mails.
- b) Activities of the Committee on Salaried Dentists will be addressed on an as required basis, utilizing conference calls and the mails.
- c) The Ad Hoc Committee on Roles and Responsibilities will present a final report to the Executive Council at the Fall planning session. It is anticipated that the Committee will be disbanded at that time.
- d) The activities of the Council on Health Care should be re-structured to improve efficiency and cost effectiveness.

RESOLVED:

- 87.68 THAT the Council on Health Care be re-structured to a Standing Committee of Executive Council, utilizing as an interim core, the current Executive Committee of Health Care, and

THAT the composition of the Committee on Health Care be reviewed.

ADOPTED

RESOLVED:

- 87.69 THAT the Council on Constitution and By-Laws proceed with the necessary By-Law amendments.

ADOPTED

At the 1987 Fall planning session, future priorities will be established, and adjustments made to the 1988 budget to reflect the resulting program plans and activities for 1988. Subject to this review:

RESOLVED:

- 87.70 THAT the appended budget be approved as a provisional budget for 1988.

ADOPTED

APPENDIX A

Commencing in 1988, the Executive Council summer pre-board meeting will be structured to allow an additional day exclusively for budget review and planning purposes. The Management Committee will meet for one day prior to Executive Council.

A five-year financial plan is appended for information.

APPENDIX A

3. Payment of Fees - Corporate Members

Management Committee reviewed the current policies associated with the payment of fees by Corporate Members as against actual practices in this regard. Information received from Corporate Members on their ability to remit fees by specified dates has been considered. The payment of membership fees as it relates to the count for seats on the CDA Board of Governors was also reviewed.

RESOLVED:

87.71 THAT, by July 31 of the current year, the number of paid-up active members of CDA, together with licensed life members, guarantee the count for board seats for the Annual and next following Interim Meeting of the Board.

THAT the previous year's figures may be utilized for this purpose, given that, by July 31, fees for the current year are paid based on these figures.

THAT only those active members paying the full CDA fee will be counted, with the exception of provisions outlined in CDA Policies for the payment of fees for student graduates and first-time CDA members.

THAT the Council on Constitution and By-laws be directed to make appropriate by-law amendments.

ADOPTED

4. Meal Allowance

The current meal allowance was reviewed by the Management Committee, and recommendations are made to address concerns that the allowance reflect realistic amounts, and that claims allowed reflect actual expenditures.

RESOLVED:

87.72 THAT the meal allowance be adjusted upward to \$10.00 for breakfast, \$12.00 for lunch and \$34.00 for dinner for a total increase of \$6.00 per day; and further,

THAT a maximum daily remuneration of \$56.00 be allowed when fully supported by receipts. When arrival and departure for a meeting necessitates partial attendance, or where the Association provides meals, the following reimbursement will be allowed when fully supported by receipts: breakfast \$10.00, lunch \$12.00, and dinner \$34.00.

THAT claims for meal allowances exceeding the limits set by CDA be disallowed, and that if a claimant makes a claim for a group meal that collectively exceeds the limit, the overage be deducted from the claimant's claim.

ADOPTED

5. FDI National Treasurer - Terms of Reference and Appointment

The current terms of reference for the position of FDI National Treasurer were reviewed. It was agreed that the annual appointment by the Board of Governors should remain in force, and that the stipulation of a maximum of four (4) years in this position should be removed.

APPENDIX B

RESOLVED:

- 87.73 THAT the terms of reference for the FDI National Treasurer be amended to extend the term not to exceed eight (8) years maximum.

DEFEATED

- 87.74 THAT the terms of reference for the FDI National Treasurer be amended to eliminate the four (4) year maximum term.

ADOPTED

6. Annual Meeting - Presidents and Chief Executive Officers

Discussion at the 1987 Interim Meeting of the CDA Board of Governors, and the background to the policy establishing this meeting was reviewed.

Management Committee remains concerned with the cost effectiveness of this meeting under the current format, scheduling, and funding arrangements.

The extremely heavy time commitment of the Management Committee, when an Annual Meeting is held in conjunction with a Convention, was also considered.

RESOLVED:

- 87.75 THAT the 1987 Annual Meeting of Presidents and Chief Executive Officers be held as planned in conjunction with the Annual Meeting of the CDA Board.

THAT the next following Annual Meeting of the Presidents and Chief Executive Officers be held in conjunction with the 1989 Interim Board Meeting.

THAT the agenda of the 1989 Interim Meeting of the Board be structured as a 1 1/2 day meeting, with the Annual Meeting of the Presidents and Chief Executive Officers being held immediately thereafter.

ADOPTED

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

7. CDA Convention Chairman and Committee

A proposal outlining objectives for CDA conventions, and terms of reference for the Chairman and Committee Members was presented to Executive Council by the Management Committee.

Executive Council has approved the appended objectives for CDA Conventions, the outline of the role of the General Chairman, and the terms of reference for the Convention Committee.

APPENDIX C

8. Review of Current Year Financial Statements

A review of the 1987 financial statements after five months of operation indicated that the projected balanced budget could be jeopardized if immediate adjustments were not introduced. The principal area of concern is the CDA Journal. Based on the current expenditure pattern, the potential for an \$80,000 Journal deficit existed. To address this problem, the Journal format will be reduced to sixty-eight (68) pages as soon as operationally possible, for the balance of 1987. Elimination of specified monthly issues will be examined by the Publications Committee. The Publications Committee has also been asked to review and recommend on the advantages of an additional advertising salesperson for the Journal, to be hired on a commission-only basis.

9. Library Services

Current policy identifies fees for library services provided to non-members. In order to discourage members making requests on behalf of non-members, and to recover a portion of the expenses incurred in providing library services, an adjustment to the current policy is required.

APPENDIX D

Effective October 1, 1987 fees will be levied on both members and non-members for utilization of the following library services: Table of Contents, Library Packages and Medline Searches. The rate for these services will be 4¢ per photocopy, plus \$2.50 for shipping and handling, with a minimum charge of \$7.50. These charges will be applied to non-members over and above those currently in effect.

Note: This change was not introduced on the recommendation of the Publications Committee and will be reviewed by Management in the future.

10. Mortgage Review

Management reviewed the feasibility of locking-in the CDA mortgage. At present, interest is paid at bank prime which is 8.75%. To lock-in, a non-refundable fee of 1/2 of 1% on the outstanding balance would be required - approximately \$2,400.00. If CDA were to lock-in for a 3-5 year term, prime would have to rise 2-2.25 points over the term to reach the break even point. Based on these factors, no change is recommended to the present mortgage arrangements.

11. Property Management

A central heating, ventilating and air conditioning computer system has been installed at a cost slightly under \$20,000.

Negotiations are underway with CCHA to take over space vacated by the Red Cross.

ACFD will soon move to the CDA building, and occupy a space of some two hundred and fifty (250) square feet. Management directed that fair market price be applied to new tenants, with consideration being given to length of lease and amount of space occupied. Such consideration could take the form of lease holds.

12. Building Contingency Reserve Fund

The terms of reference for the Building Contingency Reserve Fund were reviewed and the advantages of adding to the fund discussed. An additional \$20,000 has been added to the fund, bringing the total amount to approximately \$22,000.

13. Use of Bell Calling Cards and Corporate Credit Cards

Utilization of Bell calling cards and corporate credit cards was reviewed by the Management Committee. The major problem created through utilization of corporate credit cards is a resulting delay in submission of expense claims. This in turn makes monthly monitoring of budget expenditures extremely difficult, and causes other unnecessary administrative problems.

It was agreed that, for the time being, no change should be made to current policies. The thirty (30) day limit for submission of expense claims will be stressed, and the cooperation of all concerned sought in this regard.

14. CDA Officers Insurance Coverage - Travel and Liability

A review of current insurance coverage for travel and liability of CDA officers and senior staff has identified areas which require clarification relative to possible duplicate coverage, and insufficient coverage. The Council on Insurance and Investment has been requested to examine existing coverage, and report on necessity and benefits, with particular attention to liability coverage.

15. Library Committee

Management Committee considered a request of the Chairman, Council on Nominations, Awards and Trusts, to establish a Library Committee. Matters affecting the operation of the Sydney Wood Bradley Memorial Library will be included in the mandate of the Publications Committee. Members of Management Committee will continue to act as Trustees of the Library, as outlined in the Deed of Trust.

16. Incoming President's Schedule

The schedule for the incoming President was reviewed by Management Committee. Dr. Markey indicated he would establish his priorities on attendance at events, based on cost-effectiveness and tangible benefit to the CDA.

Utilization of members of Executive Council, members of the Board of Governors, and Council and Committee Chairpersons will be encouraged, with the dual aim of cost-effectiveness and increased profile for CDA officers and officials.

17. International Symposium on the Clinical Management of the Elderly Dental Patient

Funding support in the amount of \$1,000.00 for the International Symposium on the Clinical Management of the Elderly Dental Patient was approved, as provided for in the guidelines covering sponsorship of international dental meetings. Recognition of CDA support has been stipulated, as required in the guidelines.

18. CDA 1987 Teaching Conference

A \$10,000 grant from CFDE in support of the 1987 Teaching Conference has been augmented by a CDA grant of \$1,500.

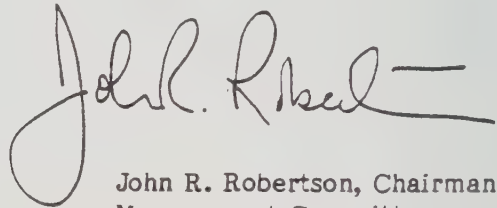
19. CDA Fluoridation Spokesperson

The necessity of identifying a CDA spokesperson on fluoridation has been endorsed. Discussion has been initiated with individuals expressing an interest and demonstrating expertise in this area. An announcement is anticipated at the Annual Meeting of the Board.

20. FDI Membership Solicitation

Concern was expressed at the decreasing numbers of Canadian FDI members. The Management Committee has directed that CDA communication tools be utilized wherever possible, and within current budget provisions, to promote FDI membership.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "John R. Robertson", with a horizontal line extending from the end of the signature.

John R. Robertson, Chairman
Management Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Management Committee with appreciation.

INTRODUCTION TO THE 1988 BUDGET

The following notes are intended to facilitate your review of the 1988 CDA Budget.

General

The 1988 CDA Budget is forecast on developed activity plans, an analysis of the 1986 financial statements, the current years' interim financial statements, and the experience of staff members in managing the programs.

The financial projections contained in this budget represent the best estimates possible at this time. Programs, however, continue to evolve and assumptions change. The budget will therefore be subjected to a further review by Executive Council at the Fall Planning Session. Any changes recommended at that time will be presented to the Board of Governors at the 1988 Interim Meeting.

Presentation

The budget is presented in three sections, each with a different degree of detail.

Section I - This is the projected income statement showing revenue and expenditure by department. It also shows the "bottom line" as either a surplus or (deficit).

Section II - This shows the various project areas under each department. All revenues and expenditures are grouped by project area.

Section III - This section provides detailed information on revenue and expenses within each project area.

"ERR" Messages

In reviewing the budget you will notice that sometimes the letters "ERR" appear under the percentage comparison columns. This is simply an indication that one of the factors in the comparison is equal to zero (0). Kindly ignore the "ERR" messages.

Explanatory Notes

Explanatory notes highlighting areas where significant changes have occurred have been provided. The notes refer to Section II and deal with individual project areas.

21-Aug-87

(INC1988)

CANADIAN DENTAL ASSOCIATION
PROJECTED INCOME STATEMENT
FOR THE YEAR ENDING DECEMBER 31, 1988

	1988 Budget	1987 Budget	1986 Actual	1988 Budget / 1987 Budget	1988 Budget / 1986 Actual
REVENUE					
EXECUTIVE	\$2,584,485	\$2,295,614	\$2,057,834	113%	126%
EDUCATION & ACCREDITATION	192,460	180,025	127,969	107%	150%
COMMUNICATIONS	914,993	838,200	998,978	109%	92%
ADMINISTRATION	293,663	285,390	273,327	103%	107%
TOTAL REVENUE	\$3,985,601	\$3,599,229	\$3,458,107	111%	115%
EXPENSE					
EXECUTIVE	\$833,419	\$780,745	\$822,971	107%	101%
EDUCATION & ACCREDITATION	521,513	422,981	354,600	123%	147%
COMMUNICATIONS	1,492,209	1,450,439	1,721,515	103%	87%
ADMINISTRATION	1,134,570	950,202	863,022	119%	131%
TOTAL EXPENSE	\$3,981,711	\$3,604,367	\$3,762,108	110%	106%
NET SURPLUS / (DEFICIT)	\$3,890	(\$5,138)	(\$304,001)	-76%	-1%

EXPLANATORY NOTES

These notes refer to Section II. Please note not all items will be addressed. For more detail, kindly refer to Section III.

REVENUE:

Executive

Corporate Fees - Fees are based on current year actual figures and do not account for anticipated growth.

Active Fees - Fees are based on current year figures with the new fee of \$290 per member factored in.

Affiliate Fees - Fees reflect a more accurate accounting of affiliate members principally in Quebec. Fees will be broken down by province in 1988, whereas this was not done in previous years.

Supporting Fees - As with Affiliate Fees, fees will be broken down by province in 1988.

Education & Accreditation

Accreditation Transfer Grant - Grants are based on current year figures and do not account for anticipated growth. Grants will be broken down by province in 1988, whereas this was not done in previous years.

Communications

Grants - CFDE has proffered an increase in funding in 1988.

Special Projects - Figure represents an administrative surcharge to be added to all special projects handled as part of the Dental Awareness Program.

Administration

FDI Receipts - Figure represents an administration surcharge on fees collected by CDA for FDI.

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SECTION 00 - Page 1

RBGT1988

1988 BUDGET - REVENUE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
EXECUTIVE					
Corporate Fees	\$99,910	\$99,768	\$79,826	100%	125%
Active Fees	2,304,630	2,180,146	1,971,552	106%	117%
Affiliate Fees	167,910	5,200	1,880	3229%	8931%
Supporting Fees	12,035	10,500	4,576	115%	263%
Total	\$2,584,485	\$2,295,614	\$2,057,834	113%	126%
EDUCATION & ACCREDITATION					
Accreditation Transfer Grant	\$123,160	\$124,350	\$62,769	99%	196%
Accreditation Surveys	30,500	22,175	24,200	137%	125%
Grants	39,000	33,500	41,000	116%	95%
Total	\$192,460	\$180,025	\$127,969	107%	150%
COMMUNICATIONS					
Grants	\$21,500	\$7,500	\$8,625	287%	249%
Student Fees	34,493	30,400	26,353	113%	131%
Dental Aptitude Test Program	165,000	150,000	176,047	110%	94%
Sales	190,000	147,000	178,205	129%	107%
Journal Revenue	454,000	508,300	392,600	89%	116%
DAP Special Projects	40,000	0	196,160	ERR	20%
Convention	10,000	(5,000)	20,988	-200%	48%
Total	\$914,993	\$838,200	\$998,978	109%	92%
ADMINISTRATION					
Interest	\$105,000	\$105,000	\$127,013	100%	83%
Rental income	184,163	174,390	137,259	106%	134%
FDI Receipts	3,500	6,000	5,258	58%	67%
Other income	1,000	0	3,797	ERR	26%
Total	\$293,663	\$285,390	\$273,327	103%	107%
GRAND TOTAL	\$3,985,601	\$3,599,229	\$3,458,107	111%	115%

EXPENSE:

Executive

Staff - Monies here allow for increases to bring salaries in line with current market trends. The figure also more accurately reflects the allocation of benefits to the department.

Dental Specialties - Represents added cost of formal committee.

Presidents & CEO - The plan to postpone this meeting to 1989 is reflected.

Education & Accreditation

Staff - Please refer to the note above re: Executive Staff.

Education & Accreditation Council - Two shorter meetings rather than one four-day meeting, are planned.

School Surveys - This represents increased activity in the area.

Dental Materials & Devices - Two meetings are planned rather than one.

Communications

Staff - Please refer to the note above re: Executive Staff.

Library - Allows for increased activity.

Students Affairs - Increase reflects accounting change to show true costs of attendance of Executive Council members at receptions.

Information Services - This project area includes the DAP. The DAP has been reduced from a scheduled expense of \$175,000 to \$150,000 for 1988. The money in this area also allows for development of new pamphlets.

(Note: The \$150,000 is the net expense of DAP to CDA. The 1986 Actual number is the gross expense; the net expense in 1986 was \$240,907).

Journal Production - This reflects a decision to restrict publication to 68 pages until such time as revenue generated from advertising covers expanded issues.

Administration

Staff - Please refer to the note above re: Executive Staff.

Operations - Reflects increasing costs, through increased activity and inflation, of general expenses such as postage and telephone.

FDI - The FDI corporate fee is expected to be close to \$23,000 in 1988. The balance is for promotional expenses.

Equipment - An allowance has been made for the purchase of new computers.

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SECTION II - Page 2

(1988EBGT)

1988 BUDGET - EXPENSE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
EXECUTIVE					
Staff	\$264,629	\$220,111	\$211,387	120%	125%
Board of Governors	129,010	111,210	115,327	112%	112%
Executive Council	79,030	64,830	63,024	122%	125%
Management Committee	136,475	135,030	142,587	101%	96%
President	72,500	65,200	96,529	111%	75%
Executive Council Liaison	10,230	20,600	9,247	50%	111%
Taxation	8,192	11,955	5,562	69%	147%
Government Relations	7,215	2,500	5,146	289%	140%
Constitution & By-laws	1,000	475	1,281	211%	78%
Ethics	1,000	5,964	841	17%	119%
Nominations	0	1,812	0	0%	ERR
Salaried Dentists	1,000	4,794	102	21%	981%
Dental Specialties	10,128	6,722	5,994	151%	169%
Roles & Responsibilities	1,490	8,482	502	18%	297%
PRUC	7,520	6,208	25,252	121%	30%
Presidents & CEOs	0	6,940	11,863	0%	0%
FDI Congress	15,000	20,000	19,467	75%	77%
Legal	21,000	20,000	29,039	105%	72%
Grants	13,000	13,000	14,600	100%	89%
Awards	3,500	4,500	754	78%	464%
Geriatric Dentistry	0	0	0	ERR	ERR
Ad Hoc Com. on MSB	6,600	0	0	ERR	ERR
President's Installation	15,000	15,000	11,120	100%	135%
Other	29,900	35,412	53,346	84%	56%
Total	\$833,419	\$780,745	\$822,971	107%	101%
EDUCATION & ACCREDITATION					
Staff	\$198,183	\$151,226	\$128,048	131%	158%
Third Party Plans	56,560	56,605	41,413	100%	137%
Education & Accreditation	97,056	81,460	70,373	119%	138%
School Surveys	92,300	62,220	61,302	148%	151%
Health Care	13,942	18,280	15,255	76%	91%
Hospital Services	18,452	15,215	18,473	121%	100%
Hospital Surveys	12,600	12,455	5,524	101%	228%
Dental Materials & Devices	15,776	9,900	6,328	159%	249%
Product Recognition	16,644	15,620	7,886	107%	211%
Total	\$521,513	\$422,981	\$354,600	123%	147%
COMMUNICATIONS					
Staff	\$409,816	\$370,539	\$326,197	111%	126%
Library	23,410	18,500	19,125	127%	122%
Student Affairs	60,702	46,750	54,384	130%	112%
DAT	139,153	115,750	143,656	120%	97%
Information Services	375,122	360,550	674,035	104%	56%
Publications Committee	10,296	7,574	6,233	136%	165%
Journal Production	371,410	439,646	396,865	84%	94%
Journal Sales	102,300	91,130	101,019	112%	101%
Total	\$1,492,209	\$1,450,439	\$1,721,515	103%	87%
ADMINISTRATION					
Staff	\$313,372	\$241,877	\$211,536	130%	148%
Operations	297,200	243,865	245,045	122%	121%
Membership	59,498	53,010	47,234	112%	126%
FDI Admin	26,000	20,000	0	130%	ERR
Equipment	127,000	104,000	75,702	122%	168%
Property	311,500	287,450	283,504	108%	110%
Total	\$1,134,570	\$950,202	\$863,022	119%	131%
GRAND TOTAL	\$3,981,711	\$3,604,366	\$3,762,108	110%	106%

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RBGT1988

1988 BUDGET - REVENUE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget / 1987 Budget	1988 Budget / 1986 Actual
EXECUTIVE					
Corporate Fees - B.C.	\$17,510	\$17,690	\$14,152	99%	124%
Corporate Fees - Alberta	12,510	12,270	9,828	102%	127%
Corporate Fees - Saskatchewan	3,600	3,595	2,876	100%	125%
Corporate Fees - Manitoba	4,600	4,735	3,788	97%	121%
Corporate Fees - Ontario	41,110	41,110	32,888	100%	125%
Corporate Fees - Quebec	12,640	12,450	9,960	102%	127%
Corporate Fees - N.B.	2,470	2,400	1,920	103%	129%
Corporate Fees - Nova Scotia	3,650	3,560	2,848	103%	128%
Corporate Fees - P.E.I.	460	450	360	102%	128%
Corporate Fees - Newfoundland	1,360	1,508	1,206	90%	113%
Active Fees - B.C.	473,280	449,672	406,575	105%	116%
Active Fees - Alberta	345,100	307,244	278,150	112%	124%
Active Fees - Saskatchewan	93,670	85,900	77,668	109%	121%
Active Fees - Manitoba	129,050	118,400	107,053	109%	121%
Active Fees - Ontario	788,800	693,135	626,705	114%	126%
Active Fees - Quebec	266,220	340,996	308,315	78%	86%
Active Fees - N.B.	57,420	49,123	44,415	117%	129%
Active Fees - Nova Scotia	102,950	91,166	82,429	113%	125%
Active Fees - P.E.I.	11,600	10,916	9,870	106%	118%
Active Fees - Newfoundland	36,540	33,593	30,374	109%	120%
Affiliate Fees - B.C.	290			ERR	ERR
Affiliate Fees - Alberta	0			ERR	ERR
Affiliate Fees - Saskatchewan	0			ERR	ERR
Affiliate Fees - Manitoba	0			ERR	ERR
Affiliate Fees - Ontario	11,020			ERR	ERR
Affiliate Fees - Quebec	143,550			ERR	ERR
Affiliate Fees - N.B.	0			ERR	ERR
Affiliate Fees - Nova Scotia	290			ERR	ERR
Affiliate Fees - P.E.I.	0			ERR	ERR
Affiliate Fees - Newfoundland	0			ERR	ERR
Affiliate Fees - Other	12,760	5,200	1,880	245%	679%
Supporting Fees - B.C.	1,305			ERR	ERR
Supporting Fees - Alberta	290			ERR	ERR
Supporting Fees - Saskatchewan	0			ERR	ERR
Supporting Fees - Manitoba	0			ERR	ERR
Supporting Fees - Ontario	3,770			ERR	ERR
Supporting Fees - Quebec	2,030			ERR	ERR
Supporting Fees - N.B.	725			ERR	ERR
Supporting Fees - Nova Scotia	290			ERR	ERR
Supporting Fees - P.E.I.	0			ERR	ERR
Supporting Fees - Newfoundland	0			ERR	ERR
Supporting Fees - Other	3,625	10,500	4,576	35%	79%
Total	\$2,584,485	\$2,295,614	\$2,057,834	113%	126%

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1988 BUDGET - REVENUE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
EDUCATION & ACCREDITATION					
Transfer Grant - B.C.	\$17,510			ERR	ERR
Transfer Grant - Alberta	12,510			ERR	ERR
Transfer Grant - Saskatchewan	3,600			ERR	ERR
Transfer Grant - Manitoba	4,600			ERR	ERR
Transfer Grant - Ontario	50,000			ERR	ERR
Transfer Grant - Quebec	27,000			ERR	ERR
Transfer Grant - N.B.	2,470			ERR	ERR
Transfer Grant - Nova Scotia	3,650			ERR	ERR
Transfer Grant - P.E.I.	460			ERR	ERR
Transfer Grant - Newfoundland	1,360	124,350	62,769	1%	2%
Survey Revenue - Schools	25,500	17,500	13,200	146%	195%
Survey Revenue - 5 Year Schools	0	0	2,500	ERR	0%
Survey Revenue - Hospitals	4,800	4,675	8,500	103%	56%
Grant - NDEB - Accreditation	18,000	15,000	15,000	120%	120%
Grant - ACFD - Accreditation	11,000	11,000	11,000	100%	100%
Grant - CFDE - Teaching Conf	10,000	7,500	15,000	133%	67%
Totals	\$192,460	\$180,025	\$127,969	107%	150%

1988 BUDGET - REVENUE					
	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
COMMUNICATIONS					
Grant - CFDE - DAP	\$10,000	\$0	\$0	ERR	ERR
Grant - CFDE - DHM	4,000	0	0	ERR	ERR
Grant - CFDE - Student Conf.	7,500	7,500	8,625	100%	87%
Student Fees - B.C.	2,958				
Student Fees - Alberta	3,448			ERR	ERR
Student Fees - Saskatchewan	1,785			ERR	ERR
Student Fees - Manitoba	2,118			ERR	ERR
Student Fees - Ontario	9,625			ERR	ERR
Student Fees - Quebec	11,743			ERR	ERR
Student Fees - N.B.	88			ERR	ERR
Student Fees - Nova Scotia	2,730			ERR	ERR
Student Fees - P.E.I.	0			ERR	ERR
Student Fees - Newfoundland	0			ERR	ERR
Student Fees - Other	0	30,400	26,353	0%	0%
DAT - Application Fees	165,000	150,000	176,047	110%	94%
DAT - Supplies	0	0	0	ERR	ERR
Sales - Seal of Recognition	28,000	24,000	10,000	117%	280%
Sales - Pamphlets	100,000	90,000	87,277	111%	115%
Sales - Films	0	0	36		
Sales - Library Services	12,000	0	100	ERR	0%
Sales - NDHM Materials	50,000	33,000	80,560	ERR	12000%
Sales - Practice Mgmt. Manual	0	0	232	152%	62%
				ERR	0%
Journal - Subscriptions	17,500	16,000	15,977	109%	110%
Journal - Commercial Advert.	405,000	460,800	349,758	88%	116%
Journal - Classified Advert.	30,000	30,000	25,875	100%	116%
Journal - Reprints	1,500	1,500	989	100%	152%
DAP Special Projects	40,000	0	196,160	ERR	20%
Annual Convention - Net	10,000	(5,000)	20,988	-200%	48%
Total	\$914,993	\$838,200	\$998,978	109%	92%

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RBCT1988

1988 BUDGET - REVENUE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
ADMINISTRATION					
Interest - Term Deposits	\$80,000	\$80,000	\$62,825	100%	127%
Interest - Current Account	25,000	25,000	62,800	100%	40%
Interest - Other	0	0	1,387	ERR	0%
Rental Income - O.D.S.	1,200	1,500	975	80%	123%
Rental Income - C.C.H.A.	81,760	53,941	47,824	152%	171%
Rental Income - Clendenning	3,150	3,150	2,573	100%	122%
Rental Income - F.M.W.	2,310	2,310	2,226	100%	104%
Rental Income - SEVEC	60,120	60,120	30,060	100%	200%
Rental Income - Red Cross	0	23,867	26,777	0%	0%
Rental Income - Ste. 105	6,078	9,117	(3,232)	67%	-188%
Rental Income - Ste. 103	11,175	0	0	ERR	ERR
Rental Income - Ste. 206	0	7,665	0	0%	ERR
Rental Income - C.Ph.A.	0	0	17,885	ERR	0%
Rental Income - Parking	6,120	6,120	5,711	100%	107%
Rental Income - Escalation	12,250	6,600	6,461	186%	190%
FDI Receipts (less payments)	3,500	6,000	5,258	58%	67%
Other - Foreign Exchange	1,000	0	1,643	ERR	61%
Other - Unallocated Income	0	0	2,154	ERR	0%
Total	\$293,663	\$285,390	\$273,327	103%	107%

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(1988EBGT)

1988 BUDGET - EXPENSE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
EXECUTIVE					
Staff/Payroll	\$188,400	\$162,470	\$146,759	116%	128%
Staff/Benefits-Transfer	36,579	26,441	19,772	138%	185%
Staff/Temporary	2,500	2,200	3,449	114%	72%
Staff/Misc. Expenses	500	0	753	ERR	66%
Staff/T&A-Executive Director	30,000	28,000	36,005	107%	83%
Staff/T&A-Other	6,650	1,000	4,650	665%	143%
Board Of Governors/T&A	84,110	82,950	73,016	101%	115%
Board of Governors/PD	44,900	28,260	42,311	159%	106%
Executive Council/T&A	31,150	32,040	29,866	97%	104%
Executive Council/PD	47,880	32,790	33,158	146%	144%
Management Committee/T&A	25,000	25,000	23,311	100%	107%
Management Committee/PD	33,600	35,150	44,396	96%	76%
Management Committee/Honoraria	77,875	74,880	74,880	104%	104%
President's Expenses/T&A	37,500	31,400	46,678	119%	80%
President's Expenses/PD	35,000	33,800	49,851	104%	70%
Executive Council Liaison/T&A	6,800	8,000	2,110	85%	322%
Executive Council Liaison/PD	3,430	12,600	7,137	27%	48%
Taxation Committee/T&A	5,600	5,085	3,378	110%	166%
Taxation Committee/PD	2,592	1,870	2,184	139%	119%
Taxation Committee/Projects	0	5,000	0	0%	ERR
Government Relations/T&A	3,975	2,500	3,742	159%	106%
Government Relations/PD	3,240	0	1,404	ERR	231%
Constitution & By-Laws/T&A	1,000	475	1,281	211%	78%
Constitution & By-Laws/PD	0	0	0	ERR	ERR
Ethics/T&A	1,000	5,340	529	19%	189%
Ethics/PD	0	624	312	0%	0%
Nominations/T&A	0	1,500	0	0%	ERR
Nominations/PD	0	312	0	0%	ERR
Salaried Dentists/T&A	1,000	4,170	102	24%	981%
Salaried Dentists/PD	0	624	0	0%	ERR
Dental Specialties/T&A	8,500	6,255	5,994	136%	142%
Dental Specialties/PD	1,628	467	0	349%	ERR
Roles & Responsibilities/T&A	1,000	8,482	502	12%	199%
Roles & Responsibilities/PD	490	0	0	ERR	ERR
Professional Resource Util./T&A	5,900	6,208	25,252	95%	23%
Professional Resource Util./PD	1,620	0	0	ERR	ERR
Presidents & CEOs/T&A	0	5,560	9,159	0%	0%
Presidents & CEOs/PD	0	1,380	2,704	0%	0%
FDI Congress/T&A	15,000	20,000	19,467	75%	77%
Legal & Consulting	21,000	20,000	29,039	105%	72%
Grants/Sponsorship	13,000	13,000	14,600	100%	89%
Nominations, Awards & Trusts	3,500	4,500	754	78%	464%
Geriatric Dentistry	0	0	0	ERR	ERR
Ad Hoc Com. on MSB	6,600	0	0	ERR	ERR
President's Installation	15,000	15,000	11,120	100%	135%
Other/PPP-Per Diem	0	4,292	4,677	0%	0%
Other/Misc. Per Diem	4,000	3,120	7,598	128%	53%
Other/Unaccountable Expense	0	0	8,667	ERR	0%
Other/Previous Year Expense	0	0	11,061	ERR	0%
Other/St. Kitts	0	0	0	ERR	ERR
Other/Haiti	5,900	8,000	0	74%	ERR
Other/Unallocated Expenses	20,000	20,000	21,344	100%	94%
Total	\$833,419	\$780,745	\$822,971	107%	101%

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(1988EBGT)

1988 BUDGET - EXPENSE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
EDUCATION & ACCREDITATION					
Staff/Payroll	\$155,600	121,380	99,206	128%	157%
Staff/Benefits-Transfer	23,783	20,146	13,366	118%	178%
Staff/Temporary	2,000	2,200	360	91%	556%
Staff/Misc. Expenses	500	0	1,299	ERR	38%
Staff/T&A-Dir. of Accred.	9,600	5,000	12,436	192%	77%
Staff/T&A-Other	6,700	2,500	1,381	268%	485%
Third Party Plans/T&A	16,820	22,555	36,967	75%	45%
Third Party Plans/PD	3,240	4,050	4,446	80%	73%
Third Party Plans/Projects	16,500	20,000	0	83%	ERR
Third Party Plans/Consultant	20,000	10,000	0	200%	ERR
Educ. & Accred./Council T&A	27,900	19,200	22,410	145%	124%
Educ. & Accred./Ch's Other T&A	4,400	6,120	3,568	72%	123%
Educ. & Accred./Documents T&A	8,100	8,010	6,805	101%	119%
Educ. & Accred./Cont. Educ. T&A	10,800	10,680	3,400	101%	318%
Educ. & Accred./Competency T&A	0	5,340	0	0%	ERR
Educ. & Accred./Joint Advis. T&A	0	0	0	ERR	ERR
Educ. & Accred./Task Force T&A	9,000	0	0		
Educ. & Accred./Director's T&A	4,400	0	0		
Educ. & Accred./Council PD	4,884	4,990	8,691	98%	56%
Educ. & Accred./Ch's Other PD	3,888	0	0		
Educ. & Accred./Documents PD	1,944	1,870	0	104%	ERR
Educ. & Accred./Cont. Educ. PD	1,944	0	1,248	ERR	156%
Educ. & Accred./Competency PD	0	1,250	0	0%	ERR
Educ. & Accred./Joint Advis. PD	0	0	0	ERR	ERR
Educ. & Accred./Task Force PD	1,296	0	0	ERR	ERR
Educ. & Accred./Cont. Educ. Proj.	0	15,000	0	0%	ERR
Educ. & Accred./Reciprocity	7,000	0	0	ERR	ERR
Educ. & Accred./Teach. Conf.	11,500	9,000	24,250	128%	47%
School Surveys/University T&A	30,800	33,330	37,025	92%	83%
School Surveys/College T&A	24,400	0	0	ERR	ERR
School Surveys/Director's T&A	13,200	15,190	7,140	87%	185%
School Surveys/Univ. Survey PD	13,600	13,700	17,136	99%	75%
School Surveys/College Survey PD	10,300	0	0	ERR	ERR
Health Care/T&A	11,500	14,850	13,539	77%	85%
Health Care/PD	2,442	3,430	1,716	71%	142%
Health Care/Projects	0	0	0	ERR	ERR
Hosp. Services/T&A	12,600	4,500	11,802	280%	107%
Hosp. Services/Chairman's T&A	1,300	6,925	1,467	19%	89%
Hosp. Services/Joint Advis. T&A	0	0	794	ERR	0%
Hosp. Services/PD	3,256	3,790	4,098	86%	79%
Hosp. Services/Chairman's PD	1,296	0	0		
Hosp. Services/Joint Advis. PD	0	0	312	ERR	0%
Hospital Surveys/T&A	8,100	8,640	3,874	94%	209%
Hospital Surveys/Director's T&A	1,800	2,085	0	86%	ERR
Hospital Surveys/Survey PD	2,700	1,730	1,650	156%	164%
Dental Mat. & Devices/T&A	13,500	8,340	5,548	162%	243%
Dental Mat. & Devices/PD	2,276	1,560	780	146%	292%
Dental Mat. & Devices/Projects	0	0	0	ERR	ERR
Product Recognition/T&A	14,700	14,680	6,950	100%	212%
Product Recognition/PD	1,944	940	936	207%	208%
Product Recognition/Projects	0	0	0	ERR	ERR
Total	\$521,513	\$422,981	\$354,600	123%	147%

21-Aug-87

(1988EBGT)

1988 BUDGET - EXPENSE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
COMMUNICATIONS					
Staff/Payroll	\$312,500	284,452	245,523	110%	127%
Staff/Benefits-Transfer	47,566	46,587	33,078	102%	144%
Staff/Temporary	17,000	17,000	21,132	100%	80%
Staff/Misc. Expenses	700	0	1,516	ERR	46%
Staff/T&A-Dir. of Communications	10,000	10,000	12,530	100%	80%
Staff/T&A-Other	22,050	12,500	12,417	176%	178%
Library/Medline	11,000	8,500	10,860	129%	101%
Library/Equip. Rental - DF & DS	770	700	646	110%	119%
Library/Supplies & Services	2,200	2,000	1,769	110%	124%
Library/Interlibrary Loans	9,000	7,000	5,485	129%	164%
Library/Membr. & Seminar Fees	220	200	158	110%	139%
Library/Ship -Translation	220	100	208	220%	106%
Student Affairs/T&A	19,970	14,000	16,053	143%	124%
Student Affairs/PD	5,382	1,250	1,677	431%	321%
Student Affairs/Translation	0	1,000	148	0%	0%
Student Affairs/Shipping & Postage	0	2,650	1,426	0%	0%
Student Affairs/Promotion	7,000	7,000	8,356	100%	84%
Student Affairs/Receptions	9,500	7,000	5,518	136%	172%
Student Affairs/Awards	850	850	730	100%	116%
Student Affairs/Pract Mgt Manual	6,000	4,000	6,408	150%	94%
Student Affairs/Student Conf.	12,000	9,000	14,058	133%	85%
Student Affairs/Misc.	0	0	10	ERR	0%
DAT Committee/T&A	13,287	18,240	25,516	73%	52%
DAT Committee/PD	3,655	1,250	3,901	292%	94%
DAT/Chalk	26,700	20,000	5,553	134%	481%
DAT/Translation	0	0	2,258	ERR	0%
DAT/Printing, Promotion & Supp.	40,000	32,000	68,518	125%	58%
DAT/Shipping & Postage	16,781	9,540	13,985	176%	120%
DAT/Grading Test Papers	8,000	8,000	23	100%	34379%
DAT/Validation	3,000	3,000	1,207	100%	249%
DAT/Fee For Service	11,000	11,000	10,258	100%	107%
DAT/Users Fee	1,600	1,600	690	100%	232%
DAT/Chalk Graders	12,460	11,120	11,747	112%	106%
DAT/Interview Workshop	2,670	0	0	ERR	ERR
Info. Services/T&A	10,680	12,510	13,830	85%	77%
Info. Services/PD	2,442	2,340	5,772	104%	42%
Info. Services/NDHM	75,000	75,000	85,404	100%	88%
Info. Services/DAP-Consulting	150,000	150,000	437,067	100%	34%
Info. Services/DAP-Admin.	22,500	22,500	21,714	100%	104%
Info. Services/Pamphlet Expense	80,000	65,000	64,468	123%	124%
Info. Services/News. & Comun.	30,000	28,000	35,859	107%	84%
Info. Services/Press Clippings	1,500	3,000	6,574	50%	23%
Info. Services/Film Distribution	3,000	2,200	3,348	136%	90%
Publications Committee/T&A	9,000	6,950	5,297	129%	170%
Publications Committee/PD	1,296	624	936	208%	138%
Publications Committee/Projects	0	0	0	ERR	ERR
Journal Prod./Translation	17,200	16,000	19,156	108%	90%
Journal Prod./Layout	90,000	97,800	101,629	92%	89%
Journal Prod./Postage	22,000	19,246	15,967	114%	138%
Journal Prod./Shipping	16,050	15,000	16,840	107%	95%
Journal Prod./Printing	204,000	271,000	228,616	75%	89%
Journal Prod./Reprinting	4,160	4,000	3,147	104%	132%
Journal Prod./Sci. Editor Serv.	9,800	9,800	7,000	100%	140%
Journal Prod./Freelance	6,000	4,800	4,510	125%	133%
Journal Prod./Photography	2,200	2,000	0	110%	ERR
Journal Sales/T&A	7,260	6,600	11,624	110%	62%
Journal Sales/Sales Mgr. Comm.	16,200	13,160	12,064	123%	134%
Journal Sales/Tel. & Telegraph	5,500	5,300	5,195	104%	106%
Journal Sales/Promotion	9,500	8,480	9,658	112%	98%
Journal Sales/Agency Commission	60,750	55,000	51,149	110%	119%
Journal Sales/Audit & Brokerage	1,590	1,590	1,041	100%	153%
Journal Sales/Mailings	0	0	1,330	ERR	0%
Journal Sales/Bus Depts	1,000	1,000	8,958	100%	11%
Journal Sales/Miscellaneous	500	0	0	ERR	ERR
Total	\$1,492,209	\$1,450,439	\$1,721,515	103%	87%

21-Aug-87

SECTION III - Page 8

(1988EBGT)

1988 BUDGET - EXPENSE

	1988 Budget	1987 Budget	1986 Actual	1988 Budget /1987 Budget	1988 Budget /1986 Actual
ADMINISTRATION					
Staff/Payroll	\$259,700	198,540	170,776	131%	152%
Staff/Pension-Employer Paid	35,200	35,000	3,478	101%	1012%
Staff/Canada Pension Plan	14,500	13,820	8,654	105%	168%
Staff/Unemployment Insurance	20,200	9,100	15,539	222%	130%
Staff/O.H.I.P.	13,000	9,740	8,598	133%	151%
Staff/Blue Cross	8,000	6,300	4,949	127%	162%
Staff/Group Plan CDSPI/53745	6,000	5,500	5,420	109%	111%
Staff/Group Plan CDSPI/53744	32,000	31,500	26,888	102%	119%
Staff/Group Plan CDSPI/Mgmt	5,000	4,750	4,088	105%	122%
Staff/Training	3,000	2,000	767	150%	391%
Staff/Personnel Advertising	2,500	1,000	4,247	250%	59%
Staff/Misc. Benefits	500	0	428	ERR	117%
Staff/Special Benefits	7,200	7,200	6,168	100%	117%
Staff/Transfer Accounts-Exec	(36,579)	(26,441)	(19,772)	138%	185%
Staff/Transfer Accounts-Ed. & Accr	(23,783)	(20,146)	(13,366)	118%	178%
Staff/Transfer Accounts-Commun.	(47,566)	(46,587)	(33,078)	102%	144%
Staff/Temporary	9,000	6,600	14,046	136%	64%
Staff/Misc. Expenses	500	0	0	ERR	ERR
Staff/T&A-Dir. of Administration	2,000	2,000	1,969	100%	102%
Staff/T&A-Other	3,000	2,000	1,738	150%	173%
Operations/Office Supplies	36,000	21,000	26,473	171%	136%
Operations/Postage	65,000	58,300	34,715	111%	187%
Operations/Shipping And Delivery	15,000	7,500	12,031	200%	125%
Operations/Memberships & Subs.	500	500	443	100%	113%
Operations/Photography	500	0	(21)	ERR	-2407%
Operations/Admin. Charges	3,000	550	2,741	545%	109%
Operations/Bad Debt Expense	0	0	(310)	ERR	0%
Operations/Misc. Office Expenses	6,000	5,000	5,002	120%	120%
Operations/Meeting Supplies	4,000	4,000	15,712	100%	25%
Operations/Telephone	70,000	65,000	65,824	108%	106%
Operations/Translation	15,000	12,000	10,452	125%	144%
Operations/Printing	43,000	31,000	39,976	139%	108%
Operations/Duplicating	12,000	15,500	10,119	77%	119%
Operations/Other Telephone Exp.	0	0	350	ERR	0%
Operations/Insurance-Exec Council	1,200	765	1,074	157%	112%
Operations/Insurance-Gen & Liab	15,000	13,750	10,464	109%	143%
Operations/Audit And Financial	11,000	9,000	10,000	122%	110%
Membership/T&A	8,035	6,950	3,711	116%	217%
Membership/PD	4,463	4,060	884	110%	505%
Membership/Promotion	12,000	10,000	8,926	120%	134%
Membership/Campaign	35,000	32,000	33,713	109%	104%
F.D.I. Administration Expense	3,000	0	0	15%	ERR
F.D.I. Corporate Fee	23,000	20,000	0	ERR	ERR
Office Equipment/Purchases	40,000	30,000	7,428	133%	538%
Office Equipment/Rental	30,000	26,000	21,961	115%	137%
Office Equipment/Maintenance	24,000	16,000	14,951	150%	161%
Office Equipment/Dep'n Expense	25,000	25,000	27,456	100%	91%
Office Equipment/Software	2,000	2,000	99	100%	2017%
Office Equipment/Supplies	6,000	5,000	3,808	120%	158%
Property/Dep'n Expense - Bldg	50,000	53,000	49,564	94%	101%
Property/Mortgage Interest	55,000	50,000	53,845	110%	102%
Property/Realty Tax	60,000	61,000	51,313	98%	117%
Property/Light, Heat & Water	55,000	55,000	48,333	100%	114%
Property/Insurance-Building	6,000	5,000	4,916	120%	122%
Property/Plumbing & Electrical	2,000	1,500	1,249	133%	160%
Property/Bldg. Main.-Supplies	10,000	5,000	8,946	200%	112%
Property/Bldg. Main.-Cleaning	19,000	14,500	15,323	131%	124%
Property/Bldg. Main.-Security	2,500	2,000	1,375	125%	182%
Property/Fire Inspection	500	450	455	111%	110%
Property/Grounds Main.-Supplies	500	500	0	100%	ERR
Property/Grounds Main.-Labour	15,000	12,000	9,905	125%	151%
Property/HVAC	20,000	15,000	15,423	133%	130%
Property/Renovations	10,000	6,000	8,974	167%	111%
Property/Legal	3,000	5,000	0	60%	ERR
Property/Realty Fees	0	0	11,178	ERR	0%
Property/Suite 105	0	0	0	ERR	ERR
Property/Miscellaneous	3,000	1,500	2,705	200%	111%
Total	\$1,134,570	\$950,202	\$863,022	119%	131%

CANADIAN DENTAL ASSOCIATION
Five Year Financial Forecast

In an attempt to project the financial position of the CDA into the future, we have developed the following financial forecast.

The figures presented are the same as those presented in the 1988 Budget with a 5% increase factored into all project areas over the years 1989 - 1992. It assumes no change to the program.

09-Sep-87

CANADIAN DENTAL ASSOCIATION
Projected Income Statement for the years ending 1987..1992
(assuming a 5% increase to the 1988 budget figures)

FIVEYRPL

	1986 Actual	1987 Budget	1988 Budget	1989 Projection	1990 Projection	1991 Projection	1992 Projection
REVENUE							
EXECUTIVE	\$2,057,834	\$2,295,614	\$2,584,485	\$2,713,709	\$2,849,395	\$2,991,864	\$3,141,458
EDUCATION & ACCREDITATION	\$127,969	\$180,025	\$192,460	\$202,083	\$212,187	\$222,797	\$233,936
COMMUNICATIONS	\$998,978	\$838,200	\$914,993	\$960,743	\$1,008,700	\$1,059,219	\$1,112,180
ADMINISTRATION	\$273,327	\$285,390	\$293,663	\$308,346	\$323,763	\$339,952	\$356,949
TOTAL	\$3,458,107	\$3,599,229	\$3,985,601	\$4,184,881	\$4,394,125	\$4,613,831	\$4,844,523
EXPENDITURE							
EXECUTIVE	\$822,972	\$780,745	\$833,419	\$875,090	\$918,844	\$964,787	\$1,013,026
EDUCATION & ACCREDITATION	\$354,602	\$422,981	\$521,513	\$547,589	\$574,968	\$603,716	\$633,902
COMMUNICATIONS	\$1,721,514	\$1,450,438	\$1,492,209	\$1,566,819	\$1,645,160	\$1,727,418	\$1,813,789
ADMINISTRATION	\$863,022	\$950,202	\$1,134,570	\$1,191,299	\$1,250,863	\$1,313,407	\$1,379,077
TOTAL	\$3,762,108	\$3,604,366	\$3,981,711	\$4,180,797	\$4,389,836	\$4,609,328	\$4,839,795
NET SURPLUS/(DEFICIT)	(\$304,001)	(\$5,138)	\$3,890	\$4,085	\$4,289	\$4,503	\$4,728

(for more detail, see attached)

CANADIAN DENTAL ASSOCIATION
Projected Income Statement for the years ending 1987..1992
(assuming a 5% increase to the 1988 budget figures)

REVENUE

	1986 Actual	1987 Budget	1988 Budget	1989 Projection	1990 Projection	1991 Projection	1992 Projection
EXECUTIVE							
Corporate Fees	\$79,826	\$99,768	\$99,910	\$104,906	\$110,151	\$115,658	\$121,441
Active Fees	1,971,552	2,180,146	2,304,630	2,419,862	2,540,855	2,667,897	2,801,292
Affiliate Fees	1,880	5,200	167,910	175,306	186,321	194,377	204,096
Supporting Fees	4,576	10,500	12,035	12,637	13,269	13,932	14,629
Total	\$2,057,834	\$2,295,614	\$2,584,485	\$2,713,709	\$2,849,395	\$2,991,864	\$3,141,458
EDUCATION & ACCREDITATION							
Accreditation Transfer (Grant							
Accreditation Surveys	\$62,769	\$124,350	\$123,160	\$129,318	\$135,784	\$142,573	\$149,702
Grants	35,200	22,175	30,300	31,815	33,406	35,076	36,830
Total	\$127,969	\$180,025	\$192,460	\$202,083	\$212,187	\$222,797	\$233,936
COMMUNICATIONS							
Grants	\$8,625	\$7,500	\$21,500	\$22,575	\$23,704	\$24,889	\$26,133
Student Fees	26,585	30,400	34,493	36,218	38,029	39,930	41,926
Dental Aptitude Test Program	176,047	150,000	165,000	173,250	181,913	191,008	200,559
Sales	175,973	147,000	190,000	198,500	209,475	219,949	230,946
Journal Revenue	392,600	508,300	454,000	476,700	500,535	525,562	551,840
DAP Special Projects	196,160	0	40,000	42,000	44,100	46,305	48,620
Convention	20,988	(5,000)	10,000	10,500	11,025	11,576	12,153
Total	\$998,978	\$838,200	\$914,993	\$960,743	\$1,008,780	\$1,059,219	\$1,112,180
ADMINISTRATION							
Interest	\$127,013	\$105,000	\$105,000	\$110,250	\$115,763	\$121,551	\$127,628
Rental Income	137,259	174,390	184,163	193,371	203,040	213,192	223,851
FBI Receipts	5,258	6,000	3,500	3,675	3,859	4,052	4,254
Other Income	3,797	0	1,000	1,050	1,103	1,158	1,216
Total	\$273,327	\$285,390	\$293,663	\$308,346	\$323,763	\$339,932	\$356,949
GRAND TOTAL	\$3,458,107	\$3,599,229	\$3,985,601	\$4,184,881	\$4,394,125	\$4,613,831	\$4,844,523

EXPENSE

	1986 Actual	1987 Budget	1988 Budget	1989 Projection	1990 Projection	1991 Projection	1992 Projection
EXECUTIVE							
Staff	\$211,387	\$220,111	\$264,629	\$277,860	\$291,733	\$306,341	\$321,658
Board of Governors	115,327	111,210	129,010	135,461	142,234	149,345	156,812
Executive Council	63,024	64,830	79,030	82,982	87,131	91,487	96,061
Management Committee	142,587	135,030	136,475	143,299	150,464	157,987	165,886
President	96,529	65,201	72,500	76,125	79,931	83,928	88,124
Executive Council Liaison	9,247	20,600	10,230	10,742	11,279	11,843	12,435
Taxation	5,562	11,955	8,192	8,502	9,032	9,483	9,957
Government Relations	5,146	2,500	7,215	7,576	7,955	8,352	8,770
Constitution & By-laws	1,281	2,475	1,000	1,050	1,103	1,158	1,216
Ethics	841	5,964	1,000	1,050	1,103	1,158	1,216
Nominations	0	1,812	0	0	0	0	0
Salaried Dentists	102	4,754	1,000	1,050	1,103	1,158	1,216
Dental Specialties	5,994	6,722	10,128	10,834	11,166	11,724	12,311
Roles & Responsibilities	5,502	8,462	1,490	1,855	1,643	1,725	1,811
PRIC	25,252	6,208	7,520	7,896	8,291	8,705	9,141
Presidents & CEOs	19,663	6,940	0	0	0	0	0
FBI Congress	19,467	20,000	15,000	15,750	16,538	17,364	18,233
Legal	29,039	20,000	21,000	22,090	23,153	24,310	25,526
Grants	14,756	13,000	13,000	13,550	14,333	15,049	15,802
Awards	0	4,500	3,500	3,675	3,859	4,052	4,254
Geriatric Dentistry	0	0	0	0	0	0	0
Ad Hoc com. on MSR	0	6,600	6,600	6,930	7,277	7,640	8,022
President's Installation	11,120	15,000	15,000	15,750	16,538	17,364	18,233
Other	53,346	35,412	29,900	31,395	33,568	35,613	37,733
Total	\$822,971	\$780,745	\$833,419	\$875,090	\$918,844	\$964,787	\$1,013,026
EDUCATION & ACCREDITATION							
Staff	\$128,048	\$151,235	\$198,183	\$208,092	\$218,497	\$229,422	\$240,893
Third Party Plans	41,413	86,605	59,560	109,384	162,357	165,475	169,749
Education & Accreditation	71,473	62,420	92,306	96,809	101,064	106,849	112,712
School Surveys	6,302	18,260	16,942	14,559	15,371	16,140	16,947
Health Care	15,255	15,213	18,452	19,375	20,343	21,360	22,429
Hospital Services	5,524	12,455	12,600	13,830	14,892	15,986	17,115
Hospital Surveys	6,328	9,900	15,776	16,569	17,393	18,263	19,176
Dental Materials & Devices	7,886	15,620	16,644	17,476	18,350	19,268	20,231
Product Recognition	0	0	0	0	0	0	0
Total	\$354,600	\$422,981	\$421,513	\$547,589	\$574,968	\$603,716	\$633,902
COMMUNICATIONS							
Staff	\$326,196	\$370,538	\$409,816	\$430,307	\$451,822	\$474,413	\$498,134
Library	19,125	18,500	23,410	24,581	25,810	27,100	28,455
Student Affairs	54,385	46,750	60,702	63,737	66,924	70,270	73,784
DAI	143,656	115,750	139,153	146,111	153,416	161,087	169,141
Information Services	674,033	360,650	378,122	393,678	413,572	434,251	455,963
Publications Committee	8,233	7,574	10,296	10,811	11,361	11,919	12,495
Journal Production	396,065	439,646	371,410	389,981	409,480	429,954	451,451
Journal Sales	101,019	91,130	102,300	107,415	112,785	118,425	124,346
Total	\$1,721,515	\$1,450,439	\$1,492,209	\$1,566,819	\$1,645,160	\$1,727,418	\$1,813,789
ADMINISTRATION							
Staff	\$211,536	\$241,877	\$313,372	\$329,041	\$349,493	\$362,767	\$380,906
Operations	245,045	243,865	297,200	312,060	327,663	344,046	361,248
Membership	47,234	53,010	59,498	62,473	65,597	68,876	72,320
FBI Admin	0	20,000	26,000	27,300	28,665	30,098	31,603
Equipment	75,702	104,000	127,000	133,350	140,018	147,018	154,369
Property	283,505	287,450	311,500	327,075	343,429	360,600	378,630
Total	\$863,022	\$950,202	\$1,134,570	\$1,191,299	\$1,250,863	\$1,313,407	\$1,379,077
GRAND TOTAL	\$3,762,108	\$3,604,366	\$3,981,711	\$4,180,797	\$4,389,836	\$4,609,328	\$4,839,795

FDI - TERMS OF REFERENCE FOR CANADIAN DELEGATES

That the Terms of Reference for Canadian Delegates to FDI be:

1. CDA will send two delegates and their spouses
 - a) the President of CDA
 - *b) one delegate - National Treasurer appointed annually for a maximum of four years.
2. Per diem as usual for the President.
3. The National Treasurer be paid the same amount as the per diem rate for a Council Chairman.
4. To be effective in 1982.
5. Cost approximately \$20,000.

*National Treasurer should be selected on the basis of experience and interest in FDI affairs for consideration of the Executive Council.

Adopted Mar., 1981

THAT the Board resolution (March 1981) covering Terms of Reference for Canadian delegates to FDI be amended to eliminate the per diem provision for CDA representatives to FDI.

Adopted Mar., 1982

CDA CONVENTIONS

The objective of the CDA Convention should be:

1. To draw a constant number of dentists to all conventions, wherever they may be, with a minimum objective of nine hundred dentists (900), and a long term objective of two thousand dentists (2000) by the year 1990.
2. To increase the number of exhibitors, in order to secure revenues for the convention. The presence of a respectable number of dentists will make it easier to sell the convention to exhibitors.
3. To place the financing of conventions on a cost recovery basis over the short term; the long term objective is to position the CDA Convention as a revenue generating activity.
4. To become an important P.R. vehicle for the Canadian Dental Association at which CDA services are promoted. The convention itself should also be perceived as a visible membership service.

In order to achieve these objectives:

1. CDA Conventions must be provided as a membership benefit. With proper planning and budgeting, convention costs should be recoverable, even within the first full operating year (1989), including any start up costs provided by CDA.
2. The choice of the city and the time of the year during which the convention is held must be made on a non-political basis. A thorough study must be made on site selection in order to allow CDA's conventions to flourish. This study should start immediately.
3. The convention must be run from CDA Headquarters. A full-time bilingual secretary should work exclusively in the CDA convention area. This person should be under the authority of the General Chairman. During the first year of operation, this person would work three days per week, to be expanded if necessary.
4. There should be an initial investment in time and money by the Canadian Dental Association, subject to review by the Management Committee, to ensure the viability of the convention and achieve these goals.
5. A General Chairman for CDA conventions will be appointed and given a three-year mandate.

.../2

The role of the General Chairman shall be:

1. To manage a Convention Committee which will work outside the political process. The President of CDA will officially appoint the Chairman, the Chairman will appoint the members. This committee will be a committee of Executive Council, without the requirement for regional representation.
2. The General Chairman and CDA staff would, in the first year, develop an operations manual for local organizing committees, chairpersons, committee people, and CDA staff to delineate the areas of responsibility of each group.
3. To hold office for three years, renewable, with no limit on the number of renewable terms being applied.

The administrative terms covering the office of General Chairman will include:

1. Drawing expense money on a quarterly basis, expenses being related to up to fifty (50) days Convention Chairman per diems. These expenditures will be drawn from the Convention Budget.
2. The General Chairman's actual travel costs will be covered to Ottawa and other convention sites, within CDA guidelines.
3. Travel to major conventions for scouting and exhibitor recruiting and information gathering will be reimbursed up to ten thousand dollars (\$10,000).

Terms of reference for Committee Members are as follows:

1. The Committee will be formed as soon as it is deemed necessary.
2. The Committee will consist of no more than four members.
3. Committee members will serve terms of three (3) years.
4. There will be one renewable term authorized by the Convention Chairman.
5. Committee members will be granted up to fifteen hundred dollars of accountable expenses (\$1,500), and one convention related business trip per year, subject to Chairman's approval.



CANADIAN DENTAL ASSOCIATION

CDA Library/Resource Centre

THE SYDNEY WOOD BRADLEY MEMORIAL LIBRARY OF THE CANADIAN DENTAL ASSOCIATION

As a free service to all members, both dentists and students, and affiliated dental groups the CDA Library/Resource Centre is presently offering the following:

- MEDLINE literature searches: this computerized information retrieval system provides access to over 3,000 medical and dental journals and produces instant bibliographies of varying length and depth of topic coverage. The Association is accepting collect calls for this service from all members. There is a \$25.00 fee for non-members for each search.
- SDI: this is a monthly current awareness bibliography. The requester's original search in MEDLINE is stored in the computer and updates are then sent automatically twelve times a year. There is a monthly charge of \$25.00 for non-members.
- Copies of contents pages of the most current dental journals. There is a monthly charge of \$5.00 to non-members for this service.
- Photocopies of journal articles. All reasonable requests will be processed free of charge to CDA members; there is a \$5.00 administrative fee for non-members.
- "Package Libraries": these are selected articles on topics of interest to the dental community and advertised each month in the Journal. One copy of each article listed is provided free of charge to members and a \$5.00 fee for non-members.
- General inquiries on dentally related topics: assistance is provided free of charge to all members; there may be a \$5.00 fee for non-members depending on the extensiveness of the request.

The Library is open from Monday to Friday between 8:30 a.m. and 4:30 p.m.

For further information please contact Trudi Di Trollo, Librarian at the Canadian Dental Association, 1815 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6, (613) 523-1770, extension 223.

GOVERNMENT RELATIONS COMMITTEE

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

ITEMS REQUIRING BOARD ACTION

The Government Relations Report includes the usual update from our Executive Director regarding contacts at all levels with government officials and agencies, and an update from Dr. Holmes regarding recent MSB discussions.

APPENDIX I-II

In addition there is an important follow-up on the meeting with Dr. Peter Glynn, that took place immediately prior to the Interim Board of Governors. Events since that time include our long awaited interview with Minister Epp, which will appear as a CDA Journal interview. This type of interview should become a more regular event, and could provide us with first hand access to key ministers or deputies in a number of areas such as Finance, Revenue, Fitness, and Consumer and Corporate Affairs. It is a unique way to communicate with key officials, while at the same time enhancing our own credibility and expertise as health providers.

Our Executive Director will also provide an update on meetings held with Health Promotion Branch, that have included Mark Sarnier and Linda Teteruck. We will be working on ways to give CDA a higher profile in the future development of the health promotion strategy.

The most important step for our Annual Board is the approval of a government relation structure for the future, the terms of reference, and the appointments to fill the new Standing Committee.

RESOLVED:

87.76 THAT the following structure of the Government Relations Committee be approved:

- 1) Chairperson
- 2) One additional member
- 3) Executive Director

ADOPTED

It is suggested that both new appointees (to be approached during the Summer of 1987 and announced to the Annual Board Meeting), be considered as being in year 1 of term 1. The flexibility of the President to make annual appointments of Council or Committee Chairpersons should allow for a change after three years or sooner, if necessary or desirable.

RESOLVED:

87.77 THAT the following terms of reference be approved:

It shall be the duty of the Government Relations Committee to:

- 1) Serve the dental community and the public through coordination of government-related activity as it pertains to all aspects of government policy development and administration, in the area of oral health.
- 2) Ensure that policies are formulated on key government issues requiring a formal CDA position.
- 3) Organize and coordinate, as appropriate, special government events such as meetings with caucus, ministerial meetings, and general departmental meetings.
- 4) Recommend editorial policy of the Journal as it relates to government relations activity.
- 5) Work toward the goal of having CDA recognized as the authoritative national voice of Canadian dentistry in federal government policy and program matters.

ADOPTED

The Government Relations Committee will coordinate a dinner function in conjunction with the Annual Board.

The activity thrust in the coming months will be a follow-up of efforts to have CDA recognized as a leader among the health professions in the areas of health promotion and prevention. Our goal should be to have oral health recognized in national health fora as an integral part of any strategy directed towards the overall improvement of health for Canadians.

Respectfully submitted,

Ron J. Markey, D.D.S., M.S.D.
Chairman
Government Relations Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Government Relations Committee with appreciation.

APPENDIX I

GOVERNMENT RELATIONS

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

SUMMARY OF ON-GOING ACTIVITIES

Schedule of activities and meetings for the period January 1987 -

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson	87-01-20	Taxation	H. Rogers	DM	CDA/Revenue Canada Taxation Relations
Neilson	87-02-09	Treasury Board	Lise Gendron	Benefits Group	Request to CDA for Information on USC & LS
Neilson	87-02-17	Public Service Commission	Huguette Labelle	Chairman	CDA/Public Services Relations
Neilson	87-02-19	Treasury Board	Bob Hoganson	Benefits Group	Request for Details of PS Dental Plan effective March 1, 1987
Neilson	87-02-19	CIDA	Denis Legris	Project Officer	Discuss CDA Application re: Thailand Project
Neilson	87-02-20	HWC	D. Nicholson	ADM/MSB	Meeting on Dental Therapy; Automated Claims Processing

GOVERNMENT RELATIONS

Page 2

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Neilson	87-02-23	Ind. Aff.	F. Drummie	Assoc. DM	CDA/Indian Affairs Relations
Neilson	87-02-24	Sec. State	W. Wells	DG - translation bureau	Translation Grants - in - AID Program Discussion
Neilson	87-02-25	Senior's Bureau of Ottawa	K. Pond, Exec Director and Board Members		Address to the Seniors' Bureau
Neilson	87-03-16	HWC	R. Laframboise	ADM - Corporate	Automated Claims Processing
Neilson Thordarson Holmes	87-03-25	HWC	D. Nicholson D. Obonsawin W. Bedford J. Hucker	ADM-MSB Sr. Dental Consultant	Dental Services Review Group Meeting
Neilson	87-05-04	Staff Dent Centre Touraine	P. Smith	Deputy Director	Training Programs for Sr. Managers
Neilson	87-05-08	HWC	W. Bedford	SDC	MSB Contract with Blue Cross
Neilson	87-05-14	RC - C&E	André Arcand	Tax Interpretation	Exemption Certificates Federal Sales Tax

GOVERNMENT RELATIONS

Page 3

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Holmes	87-05-20	HWC	D. Nicholson and Advisory Cttee to NSDT	ADM/MSB	Advisory Board National School of Dental Therapy Meeting
Neilson	87-05-21	HWC	D. Nicholson	ADM/MSB	Preventive Dental Therapist Pilot Project
Neilson Beagrie	87-06-01	CIDA	D. Legris	Project Officer	Thailand Project Discussion
Neilson Beagrie	87-06-01	HWC	M. Law W. Bedford	DM Sr. Dental Consultant	Discussion of Support for Commission on Future of Dentistry

MEMORANDUM

June 18, 1987

TO: Dr. Ron J. Markey, Chairman
Government Relations Committee

FROM: Dr. Bradley W. Holmes, CDA Representative
to M.S.B. National School of Dental
Therapy Policy Advisory Board

The enclosed materials are self explanatory. The only comments that I would make regarding the meeting was the attitude of cooperation that existed. We all have concerns about the operation of the school but the current climate of cooperation makes the discussion and decision of the Policy Advisory Committee more acceptable to all concerned.

/msg



Government
of Canada

Gouvernement
du Canada

MEMORANDUM

NOTE DE SERVICE

TO
A

Distribution

FROM
DE

Senior Consultant Dentistry
Medical Services Branch

SECURITY - CLASSIFICATION - DE SÉCURITÉ

OUR FILE/NOTRE RÉFÉRENCE

YOUR FILE/VOTRE RÉFÉRENCE

DATE

May 27, 1987.

SUBJECT
OBJET

Draft Minutes of Policy Advisory Committee

Attached are the draft minutes of the Policy Advisory Committee to the National School of Dental Therapy held in Prince Albert on May 20, 1987.

Please review the minutes for any errors or omissions and send same to me by June 15, 1987. All non-returns by that date will be considered as formal acceptance of the content.

W. R. Bedford

**MEETING
POLICY ADVISORY COMMITTEE
NATIONAL SCHOOL OF DENTAL THERAPY
PRINCE ALBERT, SASKATCHEWAN
May 20, 1987.**

In Attendance:

Mr. David Nicholson	MSB	Chairman
Dr. Jack Andrus	MSB	
Dr. Bill Bedford	MSB	
Ms. Diane Camp	Dental Therapist	
Dr. Keith Davey	N.S.D.T.	
Dr. Brad Holmes	CDA	
Dr. Pete Rieben	S.D.A.	
Dr. Maurice Simoneau	S.D.A.	

The meeting opened with a discussion that centered around a Regional controversy over the use of dental therapists to evaluate aspects of the dental therapy program.

The Committee was in unanimous agreement that there was no reason why dental therapists could not be used for this purpose as long as they were not attempting to do any treatment planning as this was outside their training and scope of duties. A letter confirming this decision should be sent to the regions. Dr. Bedford was given the responsibility to prepare the letter for the signature of the A.D.M.

The second item on the agenda dealt with having dental therapists perform additional duties such as repairing dentures. While it was recognized that many situations may arise where dental therapists with additional training could provide a worthwhile service, it was agreed that no expansion of treatment should be considered at this point in time.

Placement of new graduates was the next item and Dr. Davey advised that of a graduating class of ten students, eight would require placement immediately. One graduate is taking maternity leave and a second will return in September to complete some course requirements. There are, however, two former graduates who are also seeking employment bringing the placement requirement to ten. It was agreed that first priority should be given to placement of all graduates in the N.W.T. The chairman indicated that should circumstances dictate that this would not be possible he would ensure that the regions produced enough PY's to cover off placement of all graduates.

Dr. Davey advised the Committee that there are examples where a dentist and a dental therapist are working in harmony to supply services to some reserves and wanted to know if such an arrangement was considered acceptable. The Committee were in unanimous agreement that such an arrangement was very acceptable and should be encouraged.

Discussion then took place regarding the development of a "preventive dental therapist". This subject was being addressed by a group of CDA &MSB officials in order to inject proven preventive procedures into program areas such as Sioux Lookout in Ontario where dentists from the ODA are providing dental treatment only. Dr. Davey indicated that the N.S.D.T. was prepared to undertake the training at any time. It was agreed that this was a positive step to address a major program gap and that a protocol should be developed and costed out for consideration by the ADM.

Finally, discussion took place on the subject of both dental therapist and native representation on the Advisory Committee. It was agreed that the Committee should include one dental therapist and one native representative. The chairman asked Dr. Bedford to prepare appropriate letters to the Dental Therapist Association and to the Assembly of First Nations. The letters should include the terms of reference for the Committee.

There being no further business, the meeting was adjourned and the next meeting will be at the call of the chair.

DISTRIBUTION LIST

Dr. Jack Andrus
Regional Dental Officer
Medical Services Branch
Saskatchewan Region
1855 Smith Street
REGINA, Saskatchewan
S4P 2N5

Dr. Maurice Simoneau
S.D.A. Representative
Box 2109
MELFORD, Saskatchewan
S0E 1A0

Dr. Peter Rieben
P.A. Representative
591 - 28 St. West
PRINCE ALBERT, Saskatchewan
S6V 4T1

Dr. Keith L. Davey
Director
National School of Dental Therapy
Medical Services Branch
Health and Welfare Canada
710 - 15th Avenue East
PRINCE ALBERT, Saskatchewan
S6V 7A4

Dr. W.R. Bedford
Senior Consultant, Dentistry
Medical Services Branch
Health and Welfare Canada
Room 1110, Jeanne Mance Building
Tunney's Pasture
OTTAWA, Ontario
K1A 0L3

Ms. Diane Camp
Dental Therapist Instructor
National School of Dental Therapy
Medical Services Branch
Health and Welfare Canada
710 - 15th Avenue East
PRINCE ALBERT, Saskatchewan
S6V 7A4

- 2 -

Dr. Bradley W. Holmes
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario
K1G 3Y6

Mr. J.D. Nicholson
Assistant Deputy Minister
Medical Services Branch
Room 1940
Jeanne Mance Building
Tunney's Pasture
OTTAWA, Ontario
K1A 0L3



Health and Welfare
Canada

Santé et Bien-être social
Canada

Assistant
Deputy Minister

Sous-ministre
adjoint

Medical Services
Branch

Direction générale
des services médicaux

c.c. Drs. Holmes and Peacock

Room 1940
Jeanne Mance Building
Tunney's Pasture
OTTAWA, Ontario
K1A 0L3

Your file Votre référence

Our file Notre référence

MAY
MAI

5 1987

Dr. B. Holmes
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario
K1G 3Y6

Dear Dr. Holmes:

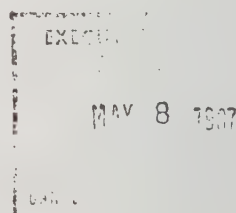
This will confirm that the first meeting of the Policy Advisory Committee to the National School of Dental Therapy will be held at the School on Wednesday, May 20, 1987. The meeting will commence at 8:30 a.m. and I anticipate adjournment by 2:00 p.m.

As I have not as yet been supplied with names and addresses for the members representing the Saskatchewan Dental Association and the Prince Albert Dental Association, I trust you will convey this information to them.

Items for the agenda are as follows:

- 1) use of dental therapists to evaluate aspects of dental therapist program;
- 2) other duties for therapists to perform;
- 3) placement of new graduates;
- 4) training of "preventive dental therapists";
- 5) dental therapist/native representation on committee.

.../2



-2-

The address for the School is as follows:

National School of Dental Therapy
710 - 15th Ave. E.
Prince Albert, Saskatchewan
S6V 7A4

(306) 922-2151

I look forward to seeing you in Prince Albert.

Yours truly;

A handwritten signature in dark ink, appearing to read "J.D. Nicholson". The signature is fluid and cursive, with a large loop at the end of the last name.

J.D. Nicholson

cc: Dr. K. Davey

NATIONAL SCHOOL OF DENTAL THERAPY
POLICY ADVISORY COMMITTEE

Committee Composition

Director General, Operations	MSB	(Chairman)
Senior Consultant Dentistry	MSB	
Director, N.S.D.T.		
CDA Representative		
Sask. Dental Assoc. Representative		
Prince Albert Dental Assoc. Representative		
2 MSB Regional Dental Officers		
- By Rotation		
- From Regions Employing D.T.s		

Meeting Site

National School of Dental Therapy

Frequency of Meetings

Minimum of one meeting per year at the call of the Chair

Cost of the Meetings

To be borne by Associations for Non-Government Representatives

Committee Reporting Structure

Recommendations from the Committee will be brought to the attention of Medical Services Branch Senior Management Committee for consideration and possible action.

TERMS OF REFERENCE

- 1) To review and make recommendations on:
 - courses taught
 - procedures taught
 - clinic operation
 - general administration procedures
- 2) To review and make recommendations on:
 - placement of new graduates
 - placement of or movement of field dental therapists
 - opening of new field locations
 - closing of present field locations
- 3) To review and make recommendations on:
 - monitoring of field dental therapists
 - supplies to field dental therapists
 - equipment to field dental therapists
 - supervision of field dental therapists
- 4) To review and make recommendations on:
 - involvement with W.H.O. and assistance in dental training to developing countries
- 5) To review and make recommendations on:
 - matters of concern from the dental profession as they relate to the National School of Dental Therapy

CONVENTION COMMITTEE

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION NOT REQUIRING BOARD ACTION

1987 Joint CDA/ODQ Convention - May 24-28, 1987 - Montreal

The 1987 joint convention attracted unprecedented numbers. Final registration figures are as follows:

Dentists	2915	(of which 329 were paying dentists from outside Quebec)
Hygienists	732	
Assistants	1008	
Administrative Personnel	461	
Technicians	38	
Spouses	344	
Exhibitors	1587	
Guests	467	
Students -		
Dental	158	
Hygiene	154	
Assistant	39	
Technician	<u>10</u>	
Total	7913	

A total of 329 out of province dentists registered for the convention. This is 64.5% over the budgeted figure of 200 out of province delegates.

The CDA/Dentsply Student Table Clinic Program was held and the following winners were declared:

1st Prize - Sandra Zakarow (University of Western Ontario)
Clinic Title - "The Porcelain Laminate Bridge - A New Alternative"

CONVENTION COMMITTEE

2nd Prize - Two students tied for second place:

Ernie Lam (University of British Columbia)
Clinic Title - "Imaging Jaw Architecture by Magnetic Resonance"

and

Raju Bhargava (University of Saskatchewan)
Clinic Title - "Glass Ionomer Cements and Microleakage"

The first prize is an expense-paid trip to the American Dental Association Convention in Las Vegas this October. Second prize is a cash award of \$150.00.

The Convention drew a record number of exhibits. Over 280 booths were sold. In addition, the joint Presidents' Gala sold out with over 400 attendees.

CDA's appreciation and congratulations are extended to Dr. Michel Jahjah and his organizing committee for an excellent convention.

1988 Convention - Edmonton, Alberta, August 21-24

Plans for the 1988 Convention proceed on schedule.

Speakers are currently being confirmed for the following subject areas:

- TMJ
- Esthetics
- Dentistry and the Law
- Low Back Pain
- Implants
- Capitation
- Disease Control
- Table Clinics

plus other areas to be announced.

A tentative budget for the convention has been developed.

APP. 1

The Convention Committee is budgeting for 750 dental registrants and 130 exhibit booths.

CONVENTION COMMITTEE

All specialty groups have been contacted concerning their intention to meet in conjunction with the CDA Convention. Replies are currently being collated. To date, the following organizations have replied that they plan to meet in conjunction with CDA:

Canadian Academy of Prosthodontists
Canadian Society of Public Health Dentists
Royal College of Dentists of Canada
Academy of General Dentistry (Alberta)
Alberta Dental Technicians' Association
CDHA
ADHA
CDAA
ADAA

The social program will include an opening reception and a Fort Edmonton Night. It is presently anticipated that one evening will be kept free for dining or shopping at West Edmonton Mall.

Promotion has begun on the meeting. Representatives of the organizing Committee attended both the Ontario Dental Association Convention in May in Toronto, and the conjoint CDA/ODQ Convention in Montreal.

The CDA Journal will commence more extensive coverage of the convention as details develop.

A theme and logo have been adopted for the meeting. All promotional materials will carry the theme "Come West - Take Home a Smile".

The CDA Board is scheduled to be held immediately prior to the Convention on August 19 and 20 with the Installation Dinner being held on Friday evening, August 19.

1989 Convention, Vancouver, B.C. - August 27-30, 1989

Convention dates have been confirmed.

A site visit is planned for June 1987 to review the meeting space that is currently being held on CDA's behalf at the New Vancouver Trade and Convention Centre, and the Pan Pacific Hotel.

CONVENTION COMMITTEE

A Convention Chairman has been selected and planning has begun for the 1989 meeting.

Respectfully submitted,

Linda Teteruck
Director of Communications

ADOPTION OF REPORT

The Board of Governors accepts the report of the Convention Committee with appreciation.

APPENDIX 1

Revenue

Budget

Exhibition Booths (130x799)	105,000	
Registration (750x199)	150,000	
Spouses Registration	29,000	
CDHA Registration	6,000	
CDAA Registration	3,000	
Out of Canada Registration	5,000	
Daily Registration	10,000	

	308,000	
		Halifax 86 334,000
		Ottawa 85 336,000

Expenses

Sunday Registration Party	30,000	
Lunches	20,000	
Exhibits	15,000	
Administration	65,000	
Postage	7,000	
Promotion	40,000	
Scientific	45,000	
Convention Center Rental	30,000	
Spouses Program	20,000	
Childrens Program	5,000	
Local Arrangements	15,000	
Brunch	10,000	
Sundrys	5,000	

	307,000	
		Halifax 86 310,000
		Ottawa 85 386,000

TAXATION COMMITTEE

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Joint Professional Committee Meeting
Friday, July 10, 1987
Ottawa, Ontario

Present:

Dr. Robert Hicks, Meeting Chairman

Canadian Bar Association

Mr. Blake Murray
Mr. Robert Diguère

Canadian Institute of Chartered Accountants

Mr. Dana Clarence
Mr. Bill Strain
Mr. Allen Taitz

Canadian Medical Association

Mr. Joe Chouinard
Mr. Doug Geekie

Canadian Dental Association

Dr. Robert Hicks
Mr. Jardine Neilson
Mrs. Sandra Deziel

The Chairman opened the meeting with a review of past activities and successes of the Joint Professional Committee. He suggested that discussion be restricted, where possible, to issues of Tax Reform proposals that relate to the business aspect of a self-employed professional practitioner. In addition, he stated that the issue of R.R.S.P. Implementation Schedule would be discussed later in the agenda, together with issues related to income tax reform.

I. Sales Tax Reform 1987 - Proposals

The Committee identified that three proposals are being considered by the federal government to broaden the tax base to include all goods and services with a minimum of exempt goods and services.

TAXATION COMMITTEE

- A. National Sales Tax
- B. Goods and Services Tax
- C. Value Added Tax

While there are differences between these three tax systems, there are common factors that apply to each. All systems will replace the present federal sales tax with a broadly-based multi stage tax that extends to the retail level. It would be levied on and collected from all businesses, in stages, as goods move from primary producers and processors to wholesalers, retailers, and finally to consumers. The system chosen will also apply to all services including dental treatment.

Under this multi-stage tax, businesses (including professional practices) will pay tax on their sales and claim a credit for any tax paid on their purchases. The credits claimed for taxes paid on overhead or operating expenses are referred to as "Input Tax Creditable Amounts" or input tax credits. It is important to note that, in the operation of a dental practice, items such as employee salary and benefits, interest, license and association dues, continuing education and convention expenses in a foreign country will not be eligible for input tax credits since no federal tax has been paid on these amounts by the dental practice.

Attached to this report (Appendix A) is a financial statement of a theoretical dental practice for the purpose of calculating the tax liability created by the proposed Goods and Service Tax system. In addition, a tax worksheet is attached to show the tax calculation. All income and expense amounts are examples and not meant to be representative of an average Canadian dental practice. Also, the application of input tax credits on this statement are included based on interpretation of the information available, at this time, on the proposed tax systems. The following is a brief description of the three proposed Sales Tax Reform Systems:

A. (National Sales Tax)

This proposal envisages a single National Sales Tax being levied on all goods and services. This tax would include a federal tax, assumed to be 8%, and a provincial sales tax (where applicable), assumed to be 7%, resulting in a national sales tax of 15%.

This tax would be identified on all invoices and would form the basis for calculating input tax credits, by business (or professional practice) producing goods or services, from their "taxed supplies". The consumer purchasing the goods or services would receive a statement or invoice with a national sales tax applied.

TAXATION COMMITTEE

With respect to dental practices, there has been no indication at this time, that provincial sales tax will be applied on dental treatment services. Hence, the federal tax rate of 8% only would apply. However, the support of the provincial governments for a "national tax collector" may indicate that provinces may wish to lower their retail sales tax rate but broaden their base to include services (Chairman's editorial comments!!)

B. (Goods and Services Tax)

This would be a federal tax only with provincial governments continuing to apply their provincial sales tax.

Similar to the national sales tax system, this tax would be levied at all levels of production of goods and services and input tax credits would apply to all businesses (and professional practices) producing goods or services on their "taxable supplies".

The difference between the Goods and Services Tax and the National Sales Tax is that GST system would not have the tax identified on the invoice. It is proposed that, 8/108 or 7.4074% of the purchase price of "taxable supplies" would be used to calculate input tax credit amounts.

With respect to dental practices, the GST would be included in the fee for dental treatment and would not be identified in the statement for services.

C. (Value Added Tax)

This federal tax proposal would, in most respects, be similar to the National Sales Tax system with the tax being identified on invoices or statements.

This system would provide flexibility to the federal government to exempt selected goods and services or selected classes of business operators. However, the White Paper on Tax Reform emphasizes the government's intent to adopt a system that is broad based with minimal exemptions.

The Joint Professional Committee discussed the impact of these three proposals on professional practices. It was identified that, at the present time, it appears that the federal government is favoring the national sales tax system, since provincial governments have indicated their support for a single "tax collector" in Canada.

The Committee has agreed to engage a tax lawyer (Mr. Blake Murray) and a tax accountant (Mr. Bill Strain) to develop a position paper to present our concerns to the federal government. In addition, a background memorandum will be produced to identify the impact of each proposal on the professional practices of law, accounting, medicine and dentistry.

TAXATION COMMITTEE

It has been identified in the White Paper on Tax Reform that all health services funded by federal or provincial governments will be exempt from federal sales tax. However, private hospitals and individual practitioners would be taxable on amounts received in receipt of services that are not insured under public (government funded) plans. Medical and dental practitioners practising under public funded plans will be liable for federal sales tax on business input items.

Information received from federal government officials indicate that decisions on a new federal sales tax system would not be finalized until after the next federal election. Therefore, present committee hearings will deal with Income Tax Reform issues at this time.

2. INCOME TAX REFORM 1987 - PROPOSALS

The Joint Professional Committee identified three areas of income tax reform proposals that will impact on professional practices:

A. Registered Retirement Savings Plans

The proposals identify a further delay in implementing the October 1986 schedule for increasing allowable tax-assisted contributions to R.R.S.P.s.

Since the Joint Professional Committee was significantly involved in convincing the federal government to increase the amount of R.R.S.P. allowable contributions, the Committee agreed that a presentation should be made identifying our concern that the October 1986 schedule has been delayed twice since its acceptance.

B. Automobile Expenses

It is proposed that full business automobile expenses will only be allowed if the vehicle is used 90% of the time for business purposes. With less 90% business use, the expenses allowable for taxation purposes will be greatly reduced. This item will impact practice expense of lawyers, accountants and medical practitioners. Therefore, the Committee agreed to include this issue in our presentation to the federal government.

C. Goodwill

In the income tax reform proposals, lifetime capital gains exemption for individuals will be limited to \$100,000. However, a capital gain on the disposition of a share of a small business corporation will be eligible for a \$500,000. exemption, where the shares are not held by anyone other than the taxpayer or persons related to him or her throughout the immediate preceding 24 months.

TAXATION COMMITTEE

In provinces where incorporation of professional practices is permitted, these small business corporations will be eligible for the \$500,000. capital gains exemptions, when the practice is sold and the goodwill portion of the sale is calculated. However, self-employed practices will only be able to apply lifetime maximum of \$100,000. capital gains exemption.

The Joint Professional Committee agreed that a proposal should be made to the federal government to request that the \$500,000. exemption should apply to the goodwill factor, when a self-employed professional practice is sold since incorporation is not permitted in all provinces in Canada.

The Committee agreed that our presentation on Income Tax Reform should be delivered to the Blenkarn Committee (Standing Committee on Finance and Economic Affairs) before August 18, 1987. In addition, an attempt will be made to meet with the Minister of Finance.

A budget is being developed for the presentation on Income Tax Reform and Sales Tax Reform. Each association will be asked to share in the cost related to these projects. It is anticipated that CDA's portion of these costs will be approximately \$3,000 to \$4,000.: an amount which is included in the 1987 Taxation Committee Budget.

The issues of Income Tax Reform and particularly Sales Tax Reform are complex. The Taxation Committee will keep the Board of Governors, the Executive Council and the members of our Association informed, through an on-going report, on the impact on dental practices and individual dental practioners.

Respectfully submitted,

Robert N. Hicks, D.D.S., M.S.
Chairman, Taxation Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Taxation Committee with appreciation.

SELF-EMPLOYED DENTAL PRACTITIONER

Estimated Values - 1987

Statement for the Purpose of Calculating
Proposed GST

INCOME:		TAXABLE SALES
Professional Income:	\$175,000.00	<u>\$175,000.00</u>
Interest Income	5,000.00	
	<u> </u>	
TOTAL INCOME:	<u>\$180,000.00</u>	
EXPENSES:		INPUT TAX CREDITABLE AMOUNTS
Salaries and Benefits	48,000.00	
Accounting	1,800.00	1,800.00
Bank Loan Interest	1,500.00	
Business Tax and Licenses	900.00	
Dental Supplies - Domestic	12,000.00	12,000.00
- Imported	3,000.00	3,000.00
Equipment Lease	4,000.00	4,000.00
Lab Charges	15,000.00	15,000.00
Laundry	700.00	700.00
Janitorial	900.00	900.00
Office Supplies	4,500.00	4,500.00
Postage	900.00	900.00
Rent	12,000.00	12,000.00
Maintenance	1,000.00	1,000.00
Utilities	1,800.00	1,800.00
Promotion	900.00	900.00
Continuing Education (Canadian)	2,000.00	2,000.00
Dues and Licenses	1,000.00	
Insurance (Practice)	1,000.00	1,000.00
Bad debts	1,500.00	1,500.00
Convention (Canadian)	1,000.00	1,000.00
Automobile (Business Use)	800.00	800.00
	<u> </u>	<u> </u>
TOTAL EXPENSES:	<u>\$116,200.00</u>	
TOTAL INPUT TAX CREDITABLE AMOUNTS:		<u>\$64,800.00</u>

- NOTES:
- All amounts are examples only and are not meant to represent an average dental practice.
 - Application of Input Tax Credits are included based upon the current information available on the Proposed Goods and Services Tax System.

SELF-EMPLOYED DENTAL PRACTITIONER

Calculation of Proposed Goods and Services Tax

TAX WORKSHEET

TAX LIABILITY CALCULATION

Total Taxable Sales	\$175,000.00
Tax Liability (8/108 or 7.4074%)	<u>\$12,963.00</u>

INPUT TAX CREDIT CALCULATION

Total Input Tax Creditable Amounts	\$64,800.00
Total Input Tax Credit (8/108 or 7.4074%)	<u>\$4,800.00</u>

<u>NET TAX LIABILITY</u>	<u>\$8,163.00</u>
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CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

MEMORANDUM

September 3, 1987

TO: Chairman and Members
Board of Governors

FROM: Sandra Deziel, Coordinator,
Taxation Committee

SUBJECT: Brief of the Joint Professional
Committee - Phase 1 Tax Reform

Attached is a copy of the brief submitted to the House of Commons Standing Committee on Finance and Economic Affairs and the Senate of Canada Standing Committee on Banking, Trade and Commerce, addressing Phase 1 of the Tax Reform Package - proposed changes to the Income Tax Act.

Dr. Hicks will make reference to the present and future tasks of the Joint Professional Committee during the presentation of the Taxation Committee Report.

A handwritten signature in dark ink, appearing to read "Sandra Deziel". The signature is fluid and cursive, with the first name "Sandra" and last name "Deziel" clearly distinguishable.

c.c. Presidents & CEO's -
Corporate Members

/msg

SAME BRIEF SUBMITTED TO
SENATE COMMITTEE.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

August 18, 1987

Clerk
Standing Committee on Finance and
Economic Affairs
House of Commons
Ottawa, Ontario
K1A 0A6

Don Blenkarn, M.P.
Chairman

Dear Sirs:

We are writing to you as the Joint Professional Committee of the Canadian Bar Association, the Canadian Dental Association, the Canadian Institute of Chartered Accountants and the Canadian Medical Association to express our common views with respect to Phase I of the Tax Reform proposed in the White Paper on Tax Reform tabled by the Minister of Finance in the House of Commons on June 18, 1987. The submissions of the joint committee are not intended to preclude further submissions by any of the above named associations. We look forward to commenting further on Phase II (Sales Tax Reform) also at the appropriate time.

In general, the Joint Professional Committee supports the direction of Phase I of the proposed Tax Reform. There are, however, several areas of common concern, which we feel compelled to address.

Registered Retirement Savings Plans

We are disappointed and concerned about the proposed delay in the phase-in of higher limits for contributions to registered retirement savings plans and the proposed slower increase in the contribution limits thereafter. Inflation has severely eroded the value of the current contribution limits. The following table illustrates the level of contributions that would have been necessary simply to maintain the value of the \$5,500 limit established in 1976:

<u>Year</u>	<u>Actual Contribution Limits</u>	<u>Inflation Adjusted 1976 Contribution Limit</u>
1976	\$5,500	\$5,500
1977	\$5,500	\$5,950
1978	\$5,500	\$6,450
1979	\$5,500	\$7,050
1980	\$5,500	\$7,775
1981	\$5,500	\$8,750
1982	\$5,500	\$9,700
1983	\$5,500	\$10,250
1984	\$5,500	\$10,700
1985	\$5,500	\$11,125
1986	\$7,500	\$11,125
1987	\$7,500	\$12,025

Extending the period of time over which the contribution limits are to be increased will reduce their real value. We note that indexing of the proposed contribution limits (to growth in average wages) will not become applicable until 1995 for registered pension plans and 1996 for registered retirement savings plans, by which time the real value of the proposed \$15,500 limit will have been severely eroded by inflation. Based on the Federal Government's own projected rates of inflation, this erosion could be as much as 20%.

Moreover, the decision to postpone the phase-in of the new limits causes us considerable concern that the Canadian government may not be committed to reform in this area.

The Joint Professional Committee was active in presenting recommendations to a Parliamentary Task Force on Pension Reform in 1983. Our recommendations at that time were based on two principles - that the current system of tax assisted retirement saving be amended in order to permit self-employed Canadians a meaningful retirement income, and that equity exist between the retirement savings programs of the employed and self-employed.

The Parliamentary Task Force on Pension Reform reported positively on our recommendations and the Joint Professional Committee was pleased when the Federal Government initiated its original program to reach these objectives. The current decision to postpone the phase in of the new limits causes us concern that the Canadian Government may no longer be committed to supporting the two important principles stated in the preceding paragraph.

We would therefore ask that consideration be given to indexing the new limits from 1991 instead of 1995 and that the Canadian government clearly reaffirm its intention to bring equity to this area by equalizing the treatment of defined benefit registered pension plans, money purchase registered pension plans and registered retirement savings plans.

Automobile Expenses

We note the proposed denial of capital cost allowance on the cost of a passenger vehicle in excess of \$20,000 and the restriction of capital cost allowance to one-fifth of the maximum allowance for the vehicle unless at least 90% of the motor vehicle's use is in the course of business or employment. While the reasonableness of the \$20,000 limit on the cost of the motor vehicle for capital cost allowance purposes may be debatable, the proposed imposition of a 90% use rule is completely arbitrary and unreasonable. We cannot see the logic of limiting a person who makes 85% use of a vehicle to 20% of the capital cost allowance, which is the same write-off available to a person who makes 21% business use of vehicle. We note that fuel, maintenance and repair costs for the vehicle, pro-rated on the proportion of business use, will continue to be available. We assume that this will require an individual taxpayer to calculate the percentage of his business use to total use and Revenue Canada to audit such claims. In light of this requirement to determine the actual percentage of business use we fail to see the logic of the proposed 90% rule. We would recommend that the 90% rule be dropped completely. However, if such a rule is to be maintained we submit that the cut-off should be at a far lower point of business use, such as 33 1/3%.

Disposition of a Small Business

We note that for 1987 and subsequent taxation years the capital gains exemption will be limited to \$100,000 of cumulative net capital gains arising on dispositions of all capital property other than qualified farm property and shares of small business corporations. The cumulative exemption for shares of small business corporations is to be increased to \$500,000 at the beginning of 1988.

In a number of cases, it is not now possible for a professional practice to be incorporated. On the sale of an unincorporated professional practice the \$500,000 capital gains exemption will not apply. Further, goodwill (which would be reflected in a higher share value of an incorporated practice) often forms a substantial part of the value of a professional practice. We would suggest that consideration be given to extending the \$500,000 capital gains exemption to unincorporated businesses and to allowing a taxpayer to shelter proceeds of disposition of an eligible capital property under the proposed \$500,000 capital gains exemption applicable to shares of small business corporations.

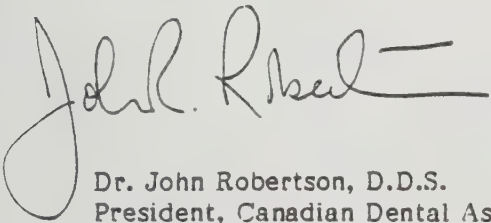
- 4 -

We appreciate having the opportunity to comment on Phase I of the White Paper and will be pleased to discuss any aspects of this brief at your convenience.

Yours very truly,



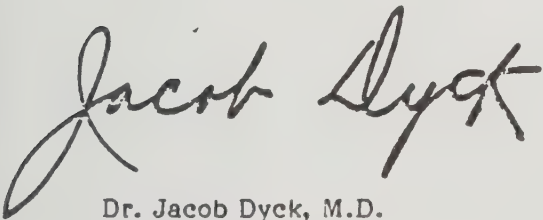
Dr. Robert N. Hicks, D.D.S., M.S.
Chairman, Joint Professional Committee



Dr. John Robertson, D.D.S.
President, Canadian Dental Association



Mr. J. Lyman MacInnis, F.C.A.
President, Canadian Institute of Chartered Accountants



Dr. Jacob Dyck, M.D.
President, Canadian Medical Association



Mr. Bryan Williams, Q.C.
President, Canadian Bar Association

- 5 -

cc: Hon. Michael H. Wilson, Minister of Finance
 Mr. S.H. Hartt, Deputy Minister, Dept. of Finance Canada
 Hon. Ray J. Hnatyshyn, PC, QC, MP, Minister of Justice
 Mr. F. Iacobucci, QC, Deputy Minister, Dept. of Justice Canada
 Hon. Jake Epp, Minister of Health and Welfare
 Dr. Maureen Law, Deputy Minister, Health and Welfare Canada
 Mr. Raymond, Garneau, MP
 Mr. Mike Cassidy, MP
 Mr. Robert Kaplan, MP
 Dr. F. J. Robertson, MP
 Ms. Sheila Copps, MP
 Mr. Howard McCurdy, MP

TAXATION COMMITTEE

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. Robert N. Hicks - Chairman, West Vancouver
Dr. John R. Robertson, Summerside
Dr. Ron J. Markey, Vancouver
Dr. Bradley W. Holmes, Kenora

ITEMS REQUIRING BOARD ACTION

1. Business Transfer Tax

On June 18, 1987 the federal government will present to Parliament a White Paper on Tax Reform for Canada. The significance of a White Paper is that it represents the policies of government that they intend to present in legislative form. The purpose of a White Paper is to identify the policy of government in order that public response can be received before the legislative process.

The Minister of Finance has indicated, on many occasions, that a major intent of the Tax Reform document is to reduce personal income tax rates and shift the tax burden over a broader base within the corporate and business community. To reach this objective, a tax referred to as a Business Transfer Tax (BTT) or a Value Added Tax (VAT) has been considered and such a tax will apply to services as well as goods. It has been suggested that dental treatment services will be included in the BTT or VAT proposal.

The Canadian Dental Association, with the assistance of this Committee, has forwarded a letter to the Minister of Finance stating our opposition to this tax and presenting a recommendation that, in the event that the BTT is implemented, a tax credit be given to dental patients who will be required to pay this tax through increased fees.

Appendix I

The Taxation Committee has revitalized the Joint Professional Committee and has invited the Canadian Bar Association, the Canadian Institute of Chartered Accountants, and the Canadian Medical Association to join with the CDA in a meeting early in July to discuss the potential for a common approach to express our opposition to this issue to government.

Appendix II

In addition to our letter and the efforts of the Joint Professional Committee, the Taxation Committee recommends a nationwide lobby focussed on letters, sent by our patients, expressing opposition to application of the BTT on dental services. A form letter will be developed by CDA and provided to dental offices for distribution to dental patients. The dental patient will sign the letter and the dental office or the patient, will mail the letter to the Minister of Finance and/or their member of Parliament (no postage required). While the project will create significant impact on the Minister of Finance, the cost of the project is not minimal. Appreciating the concerns of the Executive Council in mailing an information letter on the Federal Sales Tax issue, it is with regret that I must present the following estimate:

Six pages (one explanatory sheet, plus five copies of a sample letter) 13,000 dentists French & English	\$1,853
Mailing costs	\$767
Postage (1st class)	<u>\$7,150</u>
	\$9,770

Dental offices will be asked to copy the letters at their cost and provide batch envelopes to mail the letters of protest to the Minister of Finance (no postage required).

RESOLVED:

87.78 **THAT the Taxation Committee be authorized to proceed with the patient letter lobby project and that \$10,000 be provided from the budget to finance this project.**

DEFEATED

Direction: The Taxation Committee should prepare the necessary materials to activate the proposed lobby, and when funding is required, seek release of funds from Management Committee.

2. Canadian Dental Foundation

In finalizing the application of the Canadian Dental Foundation for "Charitable Organization" status, the Taxation Committee brings to the attention of the Board of Governors some of the requirements identified in the Income Tax Act and Information Circular 80-10R for "Registered Charities."

-
- a) A "Registered Charity" must be an independent body.
 - b) A "Charitable Organization" may be loosely characterized as an initiator of charitable activities, as distinct from an organization which funds the activities of others.
 - c) The "Charitable Organization" must expend 80% of the aggregate of amounts for which it issued donation receipts in the immediate taxation year. This does not include amounts, which are subject to the written direction of the donor that they be retained by the charity for at least ten years, and gifts that are received from other registered charities.
 - d) A "Registered Charity" may administer its own charitable activities through an appointed agent or representative.

To fulfill the requirements of the Income Tax Act, it will be necessary that major projects within the CDA that the Canadian Dental Foundation will fund, become activities of the Foundation but be administered, through a formal administrative agreement, by the Canadian Dental Association. The two most costly projects requiring Canadian Dental Foundation financial support would be the Dental Awareness Program and the Sidney Wood Bradley Library. Attached to this report is a sample Agent Agreement that would be necessary in order to receive Revenue Canada approval.

Appendix III

RESOLVED:

- 87.79** THAT the Taxation Committee proceed with the development of Agent Agreements to facilitate funding from the Canadian Dental Foundation for the Dental Awareness Program and the Sydney Wood Bradley Library.

ADOPTED

- 87.80** THAT the Agent Agreements between the Canadian Dental Foundation and the Canadian Dental Association be approved.

ADOPTED

3. CDA Taxation Seminars

A CDA Tax Seminar will take place in Halifax, Nova Scotia on Friday, October 2, 1987 (tentative date). A format similar to this successful tax seminar in Toronto will be utilized. A proposed budget for this seminar is attached.

Appendix IV

Respectfully submitted,

Robert N. Hicks, D.D.S., M.S.
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Taxation Committee with appreciation.

The Board of Governors commends the Chairman of the Taxation Committee, Dr. Robert N. Hicks, for his tremendous achievements, particularly in the area of Taxation Seminars.



APPENDIX I

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

March 17, 1987

The Honourable Michael Wilson, Minister
Department of Finance
House of Commons - Room 515-S - Centre Block
OTTAWA, Ontario
K1A 0A6

Dear Mr. Wilson:

Re: Business Transfer Tax

I am writing to you on behalf of the Canadian Dental Association with respect to the business transfer tax (BTT), which we understand will be part of the tax reform package to be introduced later this year.

Our professional advisers tell us that under the form of BTT now under consideration by your officials, it is likely that health care services will be subject to the new tax. If so, this is a matter of grave concern to our Association.

Such a tax would almost certainly result in an increase in the cost of health care to consumers. We are sure your officials have recognized this. It may be that you will consider some sort of BTT credit against income taxes to offset the impact of the BTT on lower income Canadians. Such a credit would address the regressive nature of a BTT, but would not eliminate another serious negative impact of a BTT on health care services.

Increasing the costs of health care will have the effect of discouraging consumers from utilizing health care services on a preventative basis. In our experience, consumers are very price sensitive when considering preventative health services. We believe that this sensitivity cannot be overcome by a general tax credit in the personal income tax system. We also believe that social policy ought to be directed towards the encouragement of a wider use of preventative services, as an effective way of reducing the overall level of health care costs in Canada.

.../2

The Honourable Michael Wilson

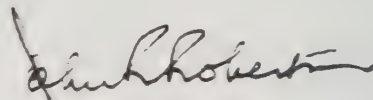
- 2 -

1987-03-17

Our Association would strongly oppose a BTT that did not zero rate or exempt from the tax, defined health care services and products. We expect that a BTT that did tax such goods and services would not be politically acceptable to a majority of Canadians.

If your officials would find it helpful to have a fuller discussion with us on these points, we would be pleased to meet with them.

Yours very truly,

A handwritten signature in dark ink, appearing to read "John R. Robertson", with a stylized flourish at the end.

John R. Robertson, D.D.S.
President

/ml

Minister of Finance



Ministre des Finances

Dr. John R. Robertson
President
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

APR 27 1987

Dear Dr. Robertson:

I am writing to acknowledge your letters of March 17 and March 25, 1987 concerning tax reform and the impact of the February 1987 budget. Your having taken time from your busy schedule to give me your views on these matters is appreciated.

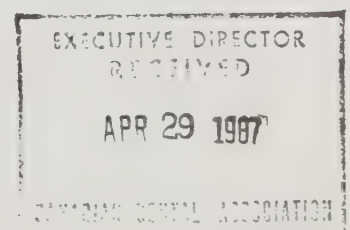
With respect to the government's commitment to reform the tax system, I have noted your observations that a reformed commodity tax system should not increase the costs of health care and that a tax credit in the personal income tax system would not be effective in encouraging consumers to utilize health care services on a preventative basis. The appropriate treatment to be accorded medical and dental services under a reformed tax system is still being considered. I assure you that I will keep your comments in mind when I make a decision.

I am sorry indeed that you do not support the budget proposals which were intended to ensure that medical and dental supplies and equipment acquired by doctors and dentists are treated identically. Your comments bring into sharp focus the fact that determining the status of goods for sales tax purposes is a major problem for the Department of National Revenue, for suppliers and for users. I understand that National Revenue officials have issued more than 20,000 separate decisions on the taxable status of goods. Given the myriad of goods available and the number of people involved in making decisions, it is not surprising that anomalies and inconsistencies do exist. I am optimistic that the tax reform process now underway will address this concern.

.../2

Ottawa - 'a K1A 0G5

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- 2 -

Thank you for having written to me on these issues. I look forward to receiving your further comments when you have had an opportunity to consider the government's tax reform package.

Yours sincerely,


Michael H. Wilson



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

May 20, 1987

Mr. Brian Williams, President
The Canadian Bar Association
Fwinton and Co.
Suite 1000 - 840 Howe Street
Vancouver, B.C.
V6Z 2M1

Dear Mr. Williams:

Re: Business Transfer Tax

As you are aware, the Minister of Finance announced the release of a White Paper on Tax Reform on June 18, 1987.

Over the past year, media speculation together with press reports following comments by the Minister of Finance, suggest that a federal sales tax upon all business transactions in Canada - including services - is being considered.

The purpose of this letter is not to review or emphasize the impact of the Business Transfer Tax or Value Added Tax on professional services. This letter is a request that representatives from the Canadian Institute of Chartered Accountants, the Canadian Bar Association, the Canadian Medical Association, and the Canadian Dental Association meet to discuss the following:

- a) The impact of such a tax on our respective areas of professional service, and on the operations of our national associations.
- b) The position or the strategy that each association is adopting in presenting its concerns related to this tax proposal to the Department of Finance.
- c) The potential for a joint proposal being put forward on the issues of common concern to our associations.
- d) The lobby activities that each association is planning or may wish to consider, to influence the final decision of the Department of Finance.

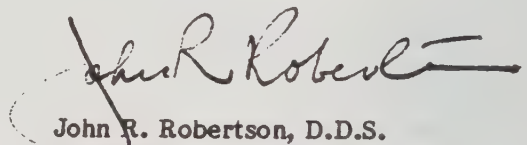
- 2 -

In the past, the Canadian Dental Association has organized and administered the affairs of a loosely-knit entity referred to as "The Joint Professional Committee". This Committee consisted of representatives from the professional associations named in this letter. The taxation issues that we have worked upon together on a formal basis are the deductibility of the continuing education expense, and improvement in self-employed contributions to Registered Retirement Savings Plans. On an informal basis, we communicated and jointly supported the opposition to the taxation on the "Work in Progress" issue. All issues resulted in positive change as a result of our working together.

The CDA is once again prepared to host a meeting of our professional association representatives, to discuss the Business Transfer Tax proposal. In the past, it has been convenient to locate such a meeting in Toronto or at our Association headquarters in Ottawa. We would again provide the meeting room and secretarial support. If acceptable, the CDA Taxation Committee Chairman, Dr. Robert Hicks (who initiated the original Joint Professional Committee concept), is available and willing to act as Chairman of this meeting. A representative of the CDA will contact your Association during the next week to make definite arrangements. A tentative date to consider is Friday, June 12, 1987 at 2:00 p.m., with a second meeting, if required, Friday July 3, 1987 at 2:00 p.m.

I trust this proposal for a meeting will meet with your approval; we again look forward to positive results.

Sincerely yours,


John R. Robertson, D.D.S.
President

c.c.: Mr. Robert Diguier, Executive Director
The Canadian Bar Association

/msg

APPENDIX III

This Agreement dated for reference _____,
1987.

BETWEEN:

CANADIAN DENTAL ASSOCIATION, a Society
incorporated under Part II of the Canada
Corporations Act, having its registered
office at 1815 Alta Vista Drive in the
City of Ottawa, Province of Ontario

(hereinafter called the "C.D.A.")

AND:

CANADIAN DENTAL FOUNDATION, a Society
incorporated under Part II of the Canada
Corporations Act, having its registered
office at 1815 Alta Vista Drive in the
City of Ottawa, Province of Ontario

(hereinafter called "the Foundation")

WHEREAS:

A. The C.D.A. has the following purposes:

B. The Foundation has the following purposes:

- (a) To create and operate a fund to be used to assist in the encouragement of good dental health in Canada including the promotion of high levels of technical competence among dentists.
- (b) To educate the community at large in the following:
 - (i) to encourage the awareness and importance of good dental health.
 - (ii) to encourage the prevention of dental diseases.
 - (iii) to encourage treatment of existing dental disease in order to prevent the loss of teeth and supporting tissue.
- (c) To support and operate a library to be known as the Sydney Wood Bradley Memorial Library whose focus will be devoted to works of concern to dentists and other dental health care professionals.
- (d) To encourage the highest level of competence amongst Canadian dentists through the support of research, lecturers, seminars and other similar programs.
- (e) To co-operate, collaborate with and assist other organizations concerned with dental health care. Any funds disbursed directly to other organizations concerned with dental health care will only be disbursed to such organizations which are qualified donees as the term is defined in the Income Tax Act of Canada.

(f) To solicit, receive and hold donations, gifts, devises and bequests for the objects of the Foundation.

(g) To disperse and distribute such money and property in the furtherance of the objects of the Foundation.

C. The C.D.A. controls the Foundation and the board of directors of the Foundation through its ownership of all the issued and outstanding shares of the Foundation.

D. The Foundation has no premises and no employee payroll and fulfills its Purposes through the actions of its Trustees.

E. The Foundation requires administrative and other services and since its incorporation the C.D.A. has the capability and desires to be engaged in performing such services for the Foundation.

WITNESSES that the parties hereto agree as follows:

1. During the term of this Agreement C.D.A. shall under the direction, control and supervision of the Foundation:

(a) assist the Foundation to achieve its Purposes; and

(b) provide space and necessary administrative services to the Foundation.

2. The Foundation shall be liable for all authorized costs, expenses and charges made by C.D.A. on its behalf and C.D.A. shall be liable for all of its own costs, expenses and charges.

3. The Foundation shall have the following obligations under this Agreement and no others:

- (a) to furnish C.D.A. from time to time with such directions, control, supervision, data and other information relating to the achievement of its Purposes as the Foundation deems necessary to C.D.A.'s performance of this Agreement; and
- (b) to pay C.D.A. compensation for services performed under this Agreement in the amount and under the circumstances described in paragraph 4 hereof.

4. In consideration for the services performed by C.D.A. hereunder, the Foundation agrees to pay C.D.A. a reasonable fee, such fee to be agreed upon by the Foundation and C.D.A. within the 60 days of the end of each fiscal year of the Foundation in respect of the fiscal year most recently ended. Failing agreement, the fee shall be determined by a single arbitrator pursuant to the Arbitration Act of Ontario then in effect.

5. C.D.A. agrees to keep accurate and complete financial records and supporting documents for all of its activities relating to this Agreement and to provide the Foundation and its representatives with a detailed breakdown of expenditures made in respect of the achievement of the Purposes including specifically:

- (a) a description of particular projects with comparisons of actual vs. budget expenditures for the Foundation's approval,
- (b) copies of vouchers supporting expenditures made on behalf of the Foundation.

6. The term of this Agreement shall commence on _____, 1987 and shall remain in full force and effect until terminated by either party. Either party shall have the power to terminate this Agreement at the end of any fiscal year of the Foundation by giving written notice of such intention to terminate not less than thirty days prior to the end of such fiscal year. In the event that either party shall materially default under this Agreement, the other party shall have the power to immediately terminate this Agreement by giving written notice of termination to the defaulting party.

7. The parties hereto shall execute such further and other documents and do such further and other things as may be necessary to carry out and give effect to the intent of this Agreement.

8. All notices required or permitted to be given hereunder shall be in writing and personally delivered to the address of the intended recipient set forth on the first page hereof or at such other address as may from time to time be notified by any of the parties hereto in the manner herein provided.

9. This Agreement constitutes the entire Agreement between the parties and there are no representations or warranties, express or implied, statutory or otherwise and no agreements collateral hereto other than as expressly set forth or referred to herein.

10. This Agreement shall be governed by and interpreted in accordance with the laws of the Province of Ontario.

11. . This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

IN WITNESS WHEREOF the parties hereto have executed this Agreement.

THE COMMON SEAL of the CANADIAN)
DENTAL ASSOCIATION was hereunto)
affixed on the ____ day of)
_____, 1987 in the presence)
of:)

C/S

THE COMMON SEAL of the CANADIAN)
DENTAL FOUNDATION was hereunto)
affixed on the ____ day of)
_____, 1987 in the presence)
of:)

C/S

CANADIAN DENTAL ASSOCIATION
TAXATION SEMINAR - HALIFAX
OCTOBER 2, 1987

Revenue

Registration Fees	80 x \$100	\$8,000.00
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Expenses

Meeting Room		\$400.00
Audio Visual		\$300.00

Luncheon and Refreshment Breaks	\$30 x 80	\$2,400.00
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Promotion and Mailing Brochure		\$600.00
1st Mailing	1000 x 37 ¢	\$370.00
Follow-up	"	\$370.00

Travel Expenses		
Airfare - Chairperson		\$1,250.00
- Coordinator		\$380.00

Meals/Accommodation	\$200 x 2 x 2	\$800.00
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Chairman's Per Diem	\$312 x 2	\$624.00
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TOTAL EXPENSES		\$7,154.00
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Projected Profit		\$846.00
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THIRD PARTY DENTAL PLANS

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

Committee Members: Dr. D. MacFarlane, Vancouver, B.C., Chairman
Dr. T. Gushue, St. John's, Newfoundland
Dr. D. Gutkin, Winnipeg, Manitoba
Dr. W. Leggett, Brampton, Ontario

Executive Liaison: Dr. D. MacFarlane, Vancouver

1. Committee Meetings

The Committee has met twice since the 1987 Interim Board of Governors meeting, on March 4 and June 15, 1987. Both meetings were held in Toronto in order to combine meetings and, thus, cut costs.

Liaison activities - Dr. Toby Gushue (committee member - Atlantic Provinces), Dr. Luc Dugal (corresponding member - Alberta) and Dr. Larry Rossoff (corresponding member - B.C.) recently met with benefits consultants in their areas to discuss, among other things, the issue of capitation. Discussions were very successful, with the benefits consultants in each case indicating that they were not in favour of capitation.

Items Requiring Board Action

2. Revision to the CDA Uniform System of Codes and List of Services

APPENDIX A *

As you were notified in our last report to the Board, the Committee has completed its major revision of the CDA Uniform System of Codes and List of Services. The Committee now feels it has a vastly improved document over the previously published version and that the new list will benefit both dentistry and the insurance industry.

For your ease of reference, a list of the reasons certain codes have been changed is provided at the end of Appendix A.

* The Uniform System of Codes and List of Services was not reproduced in the Transactions.

THIRD PARTY DENTAL PLANS

Each of the Committee's provincial corresponding members has received copies of the draft document and provided input. I would especially like to thank representatives of Ontario and Alberta, Dr. William Leggett and Dr. John Mather respectively, for providing extensive comments for committee consideration. Comments were also received from the Canadian Association of Dental Consultants. Great appreciation is also extended to Dr. Don Gutkin, of Manitoba, for developing the first draft and, over a period of two years, incorporating the suggestions provided to him from many sources.

RESOLVED:

87.31 **THAT the appended CDA Uniform System of Codes and List of Services be adopted.**

ADOPTED

Direction: **Document approved with corrections. Changes:**
 page ii **- codes for sextants to be changed from 01 to 06 to 03 to 08 to reflect FDI and International standard designation.**
 page 10 **- code 11200 Series: change 11201 to 11211; 11202 to 11222; and 11203 to 11233. (Resolution 87.44)**
 page 2 **- Series 01302 - Word "dysfunctional" should be deleted or include the word "functional".**

3. Dialogue in Dentistry

APPENDIX B

On June 13-14, 1987, representatives from all across Canada (see Appendix B for list of names) attended a seminar organized by the Chicago Dental Society (CDS) specifically for Canadian dentists. The topic was "Dialogue in Dentistry" (DID), a highly successful purchaser contact program developed by Chicago area dentists and currently being run by the CDS.

The program was developed to allow dentists to become proficient in analysing various dental plans. This detailed computer analysis has been able to show the merits of fee-for-service dentistry, as compared with alternative delivery systems, without making dentists appear self-serving.

At the seminar, participants learned how to contact an employer who has been referred by another dentist and collect data on the company's current dental plan which can, in turn, be analysed by the DID computer analyst. We also learned how to present various options to a company which has not yet had a dental plan. In each case a report is generated for use by the company in its future plans.

The CDS is totally financing this program; the service is free-of-charge to the company concerned. CDS feels that the service is paying for itself in:

THIRD PARTY DENTAL PLANS

- (a) the number of fee-for-service plans implemented or maintained;
- (b) the increased awareness of dental care fostered by DID; and
- (c) the increased profile of dentists in the business community.

The Canadian dentists involved in the seminar were equally impressed with Dialogue in Dentistry and would like to see a similar program set up in Canada. With such a sophisticated program, there will be financial implications. The Third Party Dental Plans Committee recommends:

RESOLVED:

87.82 **THAT the Third Party Dental Plans Committee be authorized to set up a pilot project under the auspices of the Dialogue in Dentistry program; and**

THAT the provinces be asked to contribute to the project on a prorated basis, and

THAT the project be run in conjunction with the provinces, and with the understanding that the funding will be shared equally between CDA and the provinces.

ADOPTED

4. Public Information Campaign

Our last report identified the Committee's efforts to mount a national public information campaign based on the Ontario campaign. Our goal was to point out the merits of fee-for-service dentistry and is centred around a booklet entitled "The Consumer's Guide to Dental Care". Over \$400,000 was raised from participating provinces to support the campaign. Approximately \$300,000 has been received to date, with the rest promised in the near future. CDA has not had to borrow any money to finance the campaign.

The funds have been used to produce 430,000 copies of the booklet for dentists' offices and to place ads in Time, Chatelaine and Maclean's magazines in May, June, and July. Articles will also appear in local community newspapers and magazines.

I am pleased to report that the Consumer's Guide to Dental Care has been a great success. In addition to the hundreds of thousands of copies which dentists have been given to hand to their patients, copies have also been requested from the public as a direct result of the ads. Some dentists have liked the booklet so much that they have ordered additional copies (total 4500 to date). We are very pleased that 10,000 copies have been requested for use in the public health system in B.C.

THIRD PARTY DENTAL PLANS

The Committee feels that "The Consumer's Guide to Dental Care" is an invaluable tool. It would appear that the only drawbacks to the booklet are that:

- (a) it has not been produced in French (Quebec opted to develop its own campaign and, without the financial support of the Quebec dentists, funds raised could not cover the costs to produce it in both languages);
- (b) there is an error in the booklet ("Ontario" is used instead of "Canada"); and
- (c) the list of provincial contacts on the inside back cover needs to be corrected to show provincial CEOs, rather than presidents (an errata sheet has been prepared for those who require it).

RESOLVED:

87.83 THAT "The Consumer's Guide to Dental Care" be referred to the Council on Information Services for consideration as part of the regular CDA pamphlet program; and

 THAT, if incorporated into the pamphlet program, the booklet be corrected and translated before the next reprinting.

ADOPTED

I would like to congratulate Manifest Communications for their outstanding efforts in mounting this campaign on behalf of Canadian dentists.

5. 1988 Budget

APPENDIX C

Attached is the outline of the Third Party Dental Plans Committee 1988 budget. Although this is an increase over last year's budget, it is hoped that the Board will recognize the importance of this burgeoning area and allocate the appropriate funds.

Although not reflected in the budget, the Committee would like to reiterate its concern over the level of staffing currently allotted to third party issues. We now enjoy one-third of Janice Forsythe's time, but this is not sufficient. With an increased level of support, we could accomplish more - both between meetings and at meetings - thus increasing cost-effectiveness. Ideally, we would require full-time staff support.

THIRD PARTY DENTAL PLANS

I would request that the Board seriously consider this request in its budget deliberations.

Items for Information - Not Requiring Board Action

6. Capitation Update

It has been reported to the Third Party Dental Plans Committee that several provincial and regional meetings have been held to discuss the problems created by a capitation system. There are still very few dentists signing up. The Ontario slogan of "No dentists, No capitation" has been adopted in several of the provinces and is working well.

We do not yet have copies of capitation contracts as there are still so few which have been signed. It is reported that these contracts change very often and that there are no longer true capitation schemes being marketed. Most of the new "managed dental" plans, as they are being called, are hybrids between a capitation and a fee-for-service system or preferred provider organization. Several of the large carriers of dental insurance in Canada will be launching new capitation-type plans as of July 1, 1987. We will report back on these new plans in future.

7. Federal Public Service Dental Plan

The Committee has reviewed the employee booklet of the Federal Public Service Dental Plan and filed a list of suggested improvements with the Treasury Board. Copies have also been sent to each of the groups covered by the plan.

8. Appreciation

On behalf of the Committee, I would like to express our appreciation of the efforts of all those who have provided input to committee deliberations over the past several months.

Respectfully submitted,

D.E. MacFarlane, D.M.D., Chairman,
Third Party Dental Plans Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Third Party Dental Plans Committee with appreciation.

The Board of Governors was commended for its outstanding achievements, particularly in the revision of the CDA Uniform SYstem of Codes and List of Services.

List of Participants

Dialogue in Dentistry Seminar

Canadian Dental Association:

Dr. Don MacFarlane
101 - 2732 W. Broadway
Vancouver, B.C. V6K 2G4
(604) 736-7375

Dr. Toby Gushue
P.O. Box 93, Village Mall
430 Topsail Rd.
St. John's, Nfld. A1E 4N1
(709) 364-2453

Dr. Les Allen
606 Ellice Ave.
Winnipeg, Man. R2X 2M4
(204) 774-3527

Ms. Janice Forsythe
Coordinator, Third Party Dental Plans Committee
1815 Alta Vista Drive
Ottawa, Ont. K1G 3Y6
(613) 523-1770

British Columbia:

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Suite 230
8055 Anderson Road.
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(604) 270-9988

Dr. Mel Sawyer
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Vancouver, B.C. V5Z 2M9
(604) 266-8910

Dr. Don Lauriente
c/o College of Dental Surgeons of B.C.
1125 West 8th Ave.
Vancouver, B.C. V6H 3N4
(604) 736-3621

Dr. Ron G. Smith
Suite 208
435 Trunk Rd.
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(604) 748-0301

Alberta:

Dr. Luc Dugal, Chairman
Dental Prepayment Advisory Committee
628 - 12th Ave. S.W.
Calgary, Alta. T2R 0H6
(403) 264-4451

Saskatchewan:

Dr. Keith I. Hamilton
1 - 3421 8th Street E.
Saskatoon, Sask. S7H 0W5
(306) 374-7272

Manitoba:

Dr. Don Gutkin
McPhillips Dental Health Centre
1368 McPhillips St.
Winnipeg, Man. R2X 2M4
(204) 633-5610

Dr. Marty Dveris
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(204) 832-1127

Ontario:

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Mr. Mike Killoran
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234 St. George Street
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Quebec:

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President and Director General
Association des chirurgiens dentistes du Québec
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(514) 282-1425

Mr. Yvan Brodeur
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Québec continued:

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(514) 282-1425

New Brunswick:

Dr. Don Williams
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(506) 855-4056

Nova Scotia:

Mr. Don Pamenter
Executive Director
Nova Scotia Dental Association
Suite 604
5901 Spring Garden Road
Halifax, N.S. B3H 1Y6
(902) 420-0088

1988 BUDGET

THIRD PARTY DENTAL PLANS COMMITTEE

Committee/Sub-Committee Meetings	\$19,000
Liaison with other organizations	2,500
TIPS Handbook (including, translation, typesetting, printing and postage)	16,500
Seminar on Alternative Delivery Systems	25,000
Consultants (economic and actuarial)	20,000
TOTAL	<u>\$82,000</u>

This budget does not include funding for staff support.

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

Committee Members: Dr. R.Y. Barolet, Québec, Québec, Chairman
Dr. G. Bowden, Winnipeg, Manitoba
Dr. E. Chan, Montréal, Québec
Dr. W.B. Chapple, Port Hope, Ontario
Dr. M. Eggert, Edmonton, Alberta
Dr. H. Limeback, Toronto, Ontario

Observer: Dr. T. Dubas, Health Protection Branch,
Health & Welfare Canada, Ottawa

1. Committee Meeting

The Committee has met once since the 1987 Interim Board of Governors meeting, on June 23, 1987. At that meeting, Drs. Bowden, Chan and Limeback were welcomed as new members. Dr. Dubas announced at this time that she would be stepping down from the Committee as she will be resigning from HPB and starting her own consulting business. I, too, announced my resignation from the Committee at this meeting. I have been appointed Dean of the Faculty of Dentistry of McGill University and feel I would have a conflict of interest as chairman.

Items Requiring Board Action

2. Administration Fees

At the request of Executive Council, the Committee has reviewed its fee structure. It proposes that the evaluation fee be increased from \$5,000 to \$7,500 and that the renewal fee of \$2,000 every three years be changed to an annual administration fee of \$2,000. Legal advice will be sought on the correct wording for the contract. The change will be effective as of the first contract signed after the wording has been changed. It will take three years before the current contracts have expired. The Committee has also adopted a policy of reviewing its fee structure every three years.

RESOLVED:

87.84 THAT, subject to obtaining legal advice on amending the contract, the fee structure for the CDA seal of recognition be increased to \$7,500 for the evaluation of an initial submission, with an additional \$2,000 maintenance fee payable annually on January 1.

ADOPTED

3. Tartar Control Statement

Committee members feel that the public is confused by the fact that tartar control toothpastes carry the CDA seal, but only for their fluoride content. The general public believes that the seal also applies to the tartar control properties of the dentifrice. The Committee therefore recommends that the fluoride statement be amended for tartar control toothpastes. The basic statement would remain the same, but with an addition regarding tartar control. This change would become effective when the contracts for the products concerned are renewed in 1988 and 1989 respectively.

RESOLVED:

87.85 THAT the following statement be adopted for all tartar control products:

" _____ contains _____ which is, in our opinion, an effective decay preventative agent, and is of significant value when used in a conscientiously applied program of oral hygiene and regular professional care. _____ has been shown to reduce the formation of tartar above the gumline, but has not been shown to have a therapeutic effect on periodontal diseases. Canadian Dental Association. (Seal)"

" _____ contient _____ qui est, à notre avis, un agent efficace de prévention de la carie et se révèle d'une utilité appréciable dans le cadre d'un programme consciencieux d'hygiène buccale et de soins professionnels réguliers. Il a été démontré que _____ réduit la formation du tartre au-dessus des gencives, mais non qu'il ait un effet thérapeutique sur les maladies parodontales. Association dentaire canadienne. (Sceau)"

ADOPTED

Items for Information - Not Requiring Board Action

4. Revisions to the Contract

Draft changes to the contract with seal of recognition holders have been suggested to CDA's lawyer, Mr. Ken Murchison. These modifications will ensure that a basic contract can be used for all of the statements the CDA may wish to grant in future. Various appended schedules will pertain to the statement in question.

In response to the issue of comparative advertising, wording suggested by our lawyer has been incorporated into the contract to allow comparisons for cosmetic claims. Manufacturers will be required to submit clear evidence of the truthfulness of any comparisons and the CDA will be the sole judge of whether the comparison should be allowed.

The Committee has noted that some of the seal of recognition holders are placing the seal and statement on separate panels of their packaging. The contract will be revised to disallow this practice.

The contract has also been updated in a few areas, consistent with current dental practice. The revised contract will be presented to the Interim Board for information.

5. **Revisions to the Anti-plaque Guidelines**

The Committee has reviewed the "Guidelines for Acceptance of Chemotherapeutic Products for the control of Supragingival Dental Plaque and Gingivitis" and "Chemotherapeutic Products for the Control of Supragingival Dental Plaque and Gingivitis" and made some minor revisions to the section on "Microbiological Assessment of Supragingival Plaque". The changes will ensure that the tests required are both meaningful and attainable in Canada.

The Committee will be able to recognize products under the new guidelines as soon as Health Protection Branch approval has been received.

6. **Public Education**

The Committee has recognized a need to inform the public of the meaning of CDA's seal of recognition. It will be investigating various means of providing such information at its next meeting.

7. **Sensitivity to Tartar Control Toothpastes**

The Committee has been made aware of several anecdotal cases of individuals being sensitive to tartar control toothpastes when they have no reaction to the regular formula. A letter will be sent to each of the manufacturers enquiring if they are aware of these reactions and if any action is being taken.

8. **Colgate Formula Change**

A change in formula for Colgate Mint Toothpaste and Gel Tartar-Fighting Formulae has been approved by the Committee. The formula now incorporates a dual phosphate system instead of a single phosphate. Additional changes in the thickening system, the flavour, the water level and the brand of silica used were also made as a result.

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION 4.

9. Close-Up Toothpaste

Close-up Toothpaste has been recognized by the Committee under the anti-caries guidelines.

10. Zendium Toothpaste

Oral-B Laboratories has discontinued production of Zendium toothpaste.

11. Appreciation

As this is my last report to the Board as Chairman of the Committee for Consumer Products Recognition, I would like to take this opportunity to thank both my Committee members for their dedication to our activities, and the members of the Board of Governors for their support of initiatives taken by this Committee. A vote of thanks is also extended to Ms. Janice Forsythe, Committee Coordinator, for her invaluable assistance.

Respectfully submitted,

Ralph Y. Barolet, DDS, MSD
Chairman, Committee for
Consumer Products Recognition

ADOPTION OF REPORT

The Board of Governors accepts the report of the Committee for Consumer Products Recognition with appreciation.

Appreciation is extended to Dr. Ralph Y. Barolet for his outstanding achievements.

PUBLICATIONS COMMITTEE

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. John Hardie - Chairman, Ottawa
Dr. P. Ralph Crawford, Winnipeg
Dr. Pierre Desautels, Montréal
Mr. A. Jardine Neilson, Ottawa

1. Committee Meetings

The Committee has met once, on May 6, 1987, at CDA Headquarters.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

2. Review of the Report of the Ad Hoc Committee on Publications

The Committee reviewed the suggestions of the Ad Hoc Committee on Publications. It was concluded that the report of the ad hoc committee would act as a guideline for initial discussions by the Committee but would not restrict the focus or direction of the Committee in seeking to increase both the financial viability or readership of CDA's publications.

3. Reports By Staff on their Current Activities

Reports were received from both the CDA Journal Editor and Information Officer on their current activities and the problems they encounter in the production and development of both the Journal and Communiqué. Suggestions emanating from these presentations included:

- the need to incorporate Communiqué-type news articles back into the Journal in a more readable and better identifiable fashion and restrict use of the Communiqué to fast-breaking, single news items on an ad hoc basis
- the need to revamp the "look" of the Journal with particular emphasis on the cover, table of contents and division of sections

-
- the need to concentrate Journal content on the interests of the general practitioner with particular emphasis on the unique types of "membership" news CDA currently publishes in the Communiqué
 - the need to develop a long term publications plan which can be reviewed and updated on a regular basis

4. Desk Top Publishing

In order to meet future objectives while also containing costs, it was decided that staff would investigate the feasibility of desk top publishing to reduce Journal lead time and typesetting costs.

5. Readership Survey

The Committee discussed the prospect of a Readership Survey to solicit the opinion of the profession on CDA's current Publications. The Committee felt that this was a valid suggestion but should be tabled until the Committee concluded on the future direction of the Journal and the Communiqué.

6. Naylor Proposal

The Committee is currently reviewing a proposal by Naylor Communication to undertake the production and development of the Journal, including the soliciting of advertising. CDA has informed Naylor that the criteria under which such a proposal will be considered is that the Journal must be produced at no cost to CDA. The Publications Committee is currently awaiting word from Naylor on the feasibility of such a proposal.

7. Oral Health and the Canadian Academy of Restorative Dentistry

The Committee learnt with regret and dismay that Oral Health has been announced as the "official publication" of the Canadian Academy of Restorative Dentistry. It was noted that the CDA President will be writing to CARD expressing CDA's disappointment in this decision. Future editorials in the Journal will feature greater details on the merits of the CDA Journal as one of the major refereed dental journals in the world.

8. Conclusions

The CDA Publications Committee is both enthusiastic and encouraged by the deliberations at the first official meeting. The members look forward to making significant progress in improving the readership, profile and financial viability of CDA's publications.

Respectfully submitted,

Dr. John Hardie, BDS, MSc, FRCDC
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Publications Committee with appreciation.

COUNCIL ON CONSTITUTION AND BY-LAWS

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. G.H. Peacock, Saskatoon
Dr. M.J. Crompton, Moncton
Dr. B. Jackson, Kitchener
Dr. M.J. Leitch, Kelowna

Dr. E.F. Allison, Calgary - Executive Liaison

1. Council Meetings

Since the 1987 Interim Meeting of the Board no formal meeting of the Council has taken place, rather all items requiring action were handled through a Conference Call on June 1, 1987 or through written correspondence.

ITEMS REQUIRING BOARD ACTION

At the 1987 Interim Meeting of the Board certain notices of motion were referred to the Council on Constitution and By-Laws for implementation within the Constitution and By-Laws. These items were reviewed by your Council and the following amendments are recommended:

2. Term of Office of the CDA President and Elected Officers

Resolution of 1987 Interim Meeting:

THAT regardless of the date of the Annual Meeting of the CDA Board of Governors at which elections of officers take place, the term of office for the President be from October 1 to September 30 of the following year;

THAT all elected officers, including members of Executive Council, assume and continue to hold office from October 1 to September 30 of the following year;

THAT this term of office be extended to all members of CDA Councils and Committees; and,

THAT the above motions be referred to the Council on Constitution and By-Laws for the necessary By-Law amendments.

RESOLVED:

87.86 That Article X, Section 8 be approved as amended.

APPENDIX 1

WITHDRAWN

NOTE: See Motion 87.67.

3. Vacancies on Executive Council

Resolution of Interim Meeting:

THAT in the event of a vacancy on Executive Council, the President shall, within 90 days, appoint a member of the Board to fill the unexpired term resulting from the vacancy.

THAT the above motion be referred to the Council on Constitution and By-Laws for necessary By-Law amendment.

RESOLVED:

87.87 THAT Article IX, Section 6 be approved as amended.

APPENDIX II

ADOPTED

4. Chairperson - Council on Nominations, Awards and Trusts and Membership Committee

At the 1987 Interim Meeting of the Board, the Chairpersons of the Council on Nominations, Awards and Trusts and the Membership Committee were altered in such a way that they not necessarily be undertaken by the Immediate Past President. As a result the current Roles and Responsibilities of the Immediate Past President require appropriate modification.

RESOLVED:

- 37.88 a) THAT Article XI, Section 4 be approved as amended.

APPENDIX III

ADOPTED

- 87.89 b) THAT Article XVI, Section 4 (i), Council on Nominations, Awards and Trusts, be approved as amended.

APPENDIX IV

ADOPTED

5. Allocation of Seats - CDA Board of Governors

Resolution of 1987 Interim Meeting:

THAT, with regard to the allocation of seats on the Canadian Dental Association Board of Governors, the corporate body be obligated to submit a list of members of the corporate body to the CDA on or before June 30 of the given year.

RESOLVED:

- 87.90 THAT Article XVIII be approved as amended.

APPENDIX V

ADOPTED

NOTE: The Board of Governors agreed with Executive Council comment to change the date from "June 30th" to "July 31st".

6. Restructuring CDSPI Board of Directors

Resolution of 1987 Interim Meeting:

As a result of the adoption by the Board of Governors of the resolution 86.60 dealing with the restructuring of the CDSPI Board of Directors, the Council on Constitution and By-Laws is directed to make the appropriate By-Law amendment.

RESOLVED:

- 87.91 THAT Article XVI, Section 4 (h) be approved as amended.

APPENDIX VI

ADOPTED

7. Chairperson

Resolution of 1987 Interim Board Meeting:

THAT the expression "Chairman" be substituted by "Chairperson" throughout the CDA Constitution and By-Laws.

RESOLVED:

87.92 THAT the expression "Chairman" be substituted by "Chairperson" throughout the CDA Constitution and By-Laws.

DEFEATED

The Articles and Sections which require changes are listed in the Appendix.

APPENDIX VII

8. In reviewing the current Constitution and By-Laws, it is noted under Article VIII, Section 13, (b), that the "Association shall also assume reasonable expenses for the Chairman of the Board of Governors, the appointed officials and the Chairman of Councils to attend sessions of the Board of Governors." It has been suggested to your Council that the above should be amended to include the Chairpersons of Committees, as this structure is becoming more prevalent. It was further recommended that such financial responsibility for those covered under this Article be contingent upon being directed by Executive Council to attend any particular session. Your Council has forwarded these recommendations to Executive Council for their consideration.

APPENDIX VIII

ITEMS FOR INFORMATION NOT REQUIRING BOARD ACTION

9. Council notes that Dr. Bruce Jackson is completing his term on Constitution and By-Laws. His contributions to the Council have been most valuable and his involvement to Councils activities will be missed.

-
10. Members of Council acknowledge with sincere appreciation the fine efforts of the staff at the CDA Headquarters.

Respectfully submitted,

George H. Peacock, D.D.S.
Chairperson

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Constitution and By-Laws with appreciation.

APPENDIX I

CURRENT

ARTICLE X

Section 8 - Term of Office

Except as otherwise provided in these By-laws the elected officers, the members of the Executive and other Councils shall assume and continue to hold office from the termination of one annual meeting to the termination of the next following annual meeting.

APPENDIX I

PROPOSED

ARTICLE X

Section 8 - Term of Office

Except as otherwise provided in these By-laws the elected officers, the members of the Executives and other Councils, and members of Committees shall assume and continue to hold office from October 1 to September 30 of the following year.

APPENDIX II

CURRENT

ARTICLE IX

Section 6 - Vacancy

In the event of a vacancy in the membership of the Executive Council, the Executive Council shall nominate and the President shall appoint a member of the Board of Governors to fill that portion of the unexpired term.

APPENDIX II

PROPOSED

ARTICLE IX

Section 6 - Vacancy

In the event of a vacancy in the membership of the Executive Council, **within 90 days**, the Executive Council shall nominate and the President shall appoint a member of the Board of Governors to fill that portion of the unexpired term.

APPENDIX III

CURRENT

ARTICLE XI

Section 4 - Roles and Responsibilities of the Immediate Past-President

- (a) shall assist the President as requested, in the performance of his duties.
- (b) shall act as Chairperson of the Council on Nominations, Awards and Trusts.
- (c) shall be a member of the Management Committee.
- (d) shall act as Chairperson of the Membership Committee (effective immediately after the annual Board of Governors' meeting).

APPENDIX III

PROPOSED

ARTICLE XI

Section 4 - Roles and Responsibilities of the Immediate Past-President

- (a) shall assist the President as requested, in the performance of his duties.
- (b) shall be a member of the Management Committee.

CURRENT

ARTICLE XVI, Section 4

(i) Council on Nominations, Awards and Trusts

The Nominations, Awards and Trusts Council shall consist of three members elected by the Board at its annual meeting pursuant to Article X, Section 6, of these By-laws, together with the Immediate Past-President, who shall be chairman. The membership should be geographically representative of the Association and should include one or more past-presidents.

It shall be the duty of the Nominations, Awards and Trusts Council:

- i) to prepare a list of all elective offices to be filled, excluding those for the Nominations, Awards and Trusts Council, and submit this list ninety (90) days before the next annual session to members of the Board of Governors, council chairmen, presidents and secretaries of Corporate members, and presidents and secretaries of Sections.
- ii) to invite, and receive in writing, nominations for each of the above elective offices. Nominations may be made only by members of the Board of Governors, council chairmen, presidents or secretaries of Corporate members, presidents or secretaries of Sections. Except in the case of nominations to the Nominations, Awards and Trusts Council itself nominations from the floor during the annual meetings will not be valid unless there are withdrawals from the list of nominations as presented by the Council on Nominations, Awards and Trusts. The Board may then make further nominations from the floor.
- iii) to rule on the eligibility of the nominees in accordance with Articles IX and X.
- iv) to make further nominations to ensure that there is at least one eligible nominee for each vacancy. The Nominations, Awards and Trusts Council shall not make nominations as to its own membership as provided in Article X, Section 6 of these By-laws.
- v) to submit an annual report, listing alphabetically all eligible nominees for each open elective office. The annual report is to be included with other council reports for advance distribution prior to the annual meeting.
- vi) to administer, publicise and report to the Executive Council and the Board of Governors on all aspects of Canadian Dental Association Trust Funds.
- vii) to administer, and report to the Executive Council and the Board of Governors on all matters relating to Canadian Dental Association Honours and Awards.

APPENDIX IV

PROPOSED

ARTICLE XVI, Section 4

(i) Council on Nominations, Awards and Trusts

The Nominations, Awards and Trusts Council shall consist of four members elected by the Board at its annual meeting pursuant to Article X, Section 6, of these By-laws. The membership should be geographically representative of the Association and should include one or more past-presidents.

It shall be the duty of the Nominations, Awards and Trusts Council:

- i) to prepare a list of all elective offices to be filled, excluding those for the Nominations, Awards and Trusts Council, and submit this list ninety (90) days before the next annual session to members of the Board of Governors, council chairmen, presidents and secretaries of Corporate members, and presidents and secretaries of Sections.
- ii) to invite, and receive in writing, nominations for each of the above elective offices. Nominations may be made only by members of the Board of Governors, council chairmen, presidents or secretaries of Corporate members, presidents or secretaries of Sections. Except in the case of nominations to the Nominations, Awards and Trusts Council itself nominations from the floor during the annual meetings will not be valid unless there are withdrawals from the list of nominations as presented by the Council on Nominations, Awards and Trusts. The Board may then make further nominations from the floor.
- iii) to rule on the eligibility of the nominees in accordance with Articles IX and X.
- iv) to make further nominations to ensure that there is at least one eligible nominee for each vacancy. The Nominations, Awards and Trusts Council shall not make nominations as to its own membership as provided in Article X, Section 6 of these By-laws.
- v) to submit an annual report, listing alphabetically all eligible nominees for each open elective office. The annual report is to be included with other council reports for advance distribution prior to the annual meeting.
- vi) to administer, publicise and report to the Executive Council and the Board of Governors on all aspects of Canadian Dental Association Trust Funds.
- vii) to administer, and report to the Executive Council and the Board of Governors on all matters relating to Canadian Dental Association Honours and Awards.

APPENDIX V

CURRENT

ARTICLE XVIII

LIST OF ACTIVE MEMBERS

A list setting forth in alphabetical order the names and addresses of all licensed dentists recommended by each Corporate member for admission to and/or continuance of Active membership shall be submitted annually, on or before **March 31st** in each year.

Forthwith upon the admission of any Individual member to membership in the Association, a membership card shall be forwarded to each member. Every person included in the list of recommended licensed dentists submitted by a Corporate member shall be deemed to be an applicant for membership in the Association unless, within thirty days of receipt of such application of his membership card in the Association, he shall notify the Executive Director that he does not desire to be or to continue to be a member.

APPENDIX V

PROPOSED

ARTICLE XVIII

LIST OF ACTIVE MEMBERS

A list setting forth in alphabetical order the names and addresses of all licensed dentists recommended by each Corporate member for admission to and/or continuance of Active membership shall be submitted annually, on or before **June 30th** in each year.

Forthwith upon the admission of any Individual member to membership in the Association, a membership card shall be forwarded to each member. Every person included in the list of recommended licensed dentists submitted by a Corporate member shall be deemed to be an applicant for membership in the Association unless, within thirty days of receipt of such application of his membership card in the Association, he shall notify the Executive Director that he does not desire to be or to continue to be a member.

CURRENT

ARTICLE XVI, Section 4

(h) Council on Insurance and Investment

The Canadian Dental Association has delegated to the Canadian Dental Service Plans Inc. the functions of the Council on Insurance and Investment as a result of an administrative agreement between the two organizations. This agreement is to be reviewed annually by the Board of Governors of the Canadian Dental Association and Canadian Dental Service Plans Inc.

The Canadian Dental Association shall appoint two directors, provided that one such director shall be a resident of the Province of Ontario and the other shall be a resident of the Province of Quebec, providing this is done in consultation with Ontario and Quebec.

It shall be the duty of the Council on Insurance and Investment:

- i) to recommend to the Executive Council the kinds of insurance and terms of coverage which are desirable for the membership to carry and which can be advantageously purveyed to the membership on a group basis;
- ii) to survey the insurance market to determine the costs, terms and conditions of available coverage;
- iii) to negotiate and recommend for approval to the Executive Council the costs, terms and conditions of contracts with the chosen carriers;
- iv) to periodically review the insurance contracts in order to determine the suitability of contracts and the possibility of improved terms and of more economic terms and to assess the proposals of competing carriers;
- v) to recommend to the Executive Council the time and manner of distribution of surplus or reserve funds;
- vi) to advise on and review Association-sponsored pension and retirement savings plans;
- vii) to report annually all actions to the Board of Governors.

PROPOSED

ARTICLE XVI, Section 4

(h) Council on Insurance and Investment

The Canadian Dental Association has delegated to the Canadian Dental Service Plans Inc. the functions of the Council on Insurance and Investment as a result of an administrative agreement between the two organizations. This agreement is to be reviewed annually by the Board of Governors of the Canadian Dental Association and Canadian Dental Service Plans Inc.

The Canadian Dental Association shall appoint two voting directors to the Board of the Canadian Dental Service Plans Inc. One of these directors will be appointed at large by the Canadian Dental Association. The other voting director shall be appointed from Executive Council. This appointee will serve as the Executive Liaison to the Council on Insurance and Investment.

It shall be the duty of the Council on Insurance and Investment:

- i) to recommend to the Executive Council the kinds of insurance and terms of coverage which are desirable for the membership to carry and which can be advantageously purveyed to the membership on a group basis;
- ii) to survey the insurance market to determine the costs, terms and conditions of available coverage;
- iii) to negotiate and recommend for approval to the Executive Council the costs, terms and conditions of contracts with the chosen carriers;
- iv) to periodically review the insurance contracts in order to determine the suitability of contracts and the possibility of improved terms and of more economic terms and to assess the proposals of competing carriers;
- v) to recommend to the Executive Council the time and manner of distribution of surplus or reserve funds;
- vi) to advise on and review Association-sponsored pension and retirement savings plans;
- vii) to report annually all actions to the Board of Governors.

APPENDIX VII

The Articles, Sections, and other items wherein the terminology "Chairman" is recommended to be changed to "Chairperson" are as listed below:

- 1) Index: Article VIII - Section 15
Article X - Section 1
Article XIV - Section 7
- 2) Article VI - Section 3 (b)
- 3) Article VIII - Section 1 (c)
- 4) Article VIII - Section 11
- 5) Article VIII - Section 13 (b)
- 6) Article VIII - Section 14
- 7) Article VIII - Section 15
- 8) Article X - Introduction
- 9) Article X - Section 1
- 10) Article X - Section 5
- 11) Article XIV - Section 7
- 12) Article XVI - Section 3 (d - e - f - g)
- 13) Article XVI - Section 4 (c - e - f)
- 14) Article XVI - Section 4 - i) i - ii
- 15) Article XVII - b) vii)
- 16) Article XXVII - Section 1

The College of Dental Surgeons of Saskatchewan

109 - 514 - 23rd STREET EAST
SASKATOON, SASK.
S7K 0J8

G. H. PEACOCK, D.D.S.
SECRETARY-REGISTRAR-TREASURER
(306) - 244-5072

June 2, 1987

Mr. Jardine Neilson,
Executive Director,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario,
K1G 3Y6.

Dear Mr. Neilson:

At a recent meeting of the Council on Constitution and Bylaws, discussion took place respecting Article VI11, Section 13(b) - Financial Responsibility of the Constitution and Bylaws of the Canadian Dental Association.

At the present time this section reads as follows:

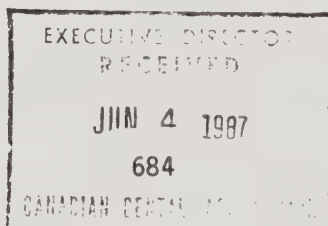
" The Association shall also assume reasonable expenses for the Chairman of the Board of Governors, the appointed officials and the chairman of councils to attend sessions of the Board of Governors"

The members of Council would recommend consideration by Executive Council as to whether this should be amended to include Committees. It is known that CDA pays for the chairpersons of standing committees of the Executive Council when they present to the Board, and in the light that Committee structure is becoming more prevalent it may be preferable to incorporate this fact within the bylaws.

In reviewing this section, members of Council also expressed some concern that under the present status it could be interpreted that 'reasonable expenses' could be paid to certain individuals, ie chairman of councils, for attending the Board sessions, whether or not they were to present a report or not. Your Councils members were of the opinion that Executive Council may wish to tighten this up. Council in recommending this consideration in no way is suggesting that this section has or is currently being abused, only that the potential for such abuse may be perceived to exist.

Thanking you for bringing this to the attention of Executive Council.

Yours sincerely,



G.H. Peacock,
Chairman.

cc. Dr. Allison

DENTAL MATERIALS AND DEVICES

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

Council Members: Dr. R.Y. Barolet, Québec, Québec, Chairman
Dr. P. Blais, Observer, Health & Welfare Canada
Dr. P. Desautels, Montréal, Québec
Dr. L. Johnson, London, Ontario
Dr. D. Jones, Halifax, N.S.
Dr. R. Roydhouse, Vancouver, B.C.
Dr. D. Smith, Toronto, Ontario
Dr. P.T. Williams, Winnipeg, Manitoba

Executive Liaison: Dr. Kevin L. Roach, Pembroke, Ontario

1. Council Meeting

The Council met for the first time this year on May 15, 1987 in Ottawa. The meeting scheduled for last December was cancelled in order to assist CDA in its efforts to balance the budget.

Items Requiring Board Action

2. Mercury Toxicity of Dental Amalgam

Dr. Murray Vimy recently addressed the Council on the results of research he has done in conjunction with Dr. Fritz Lorscheider on the mercury toxicity of dental amalgam. Council found this to be an interesting presentation but did not change its previously adopted view that overall current research on the use of silver dental amalgam "suggests that amalgam continues to demonstrate clear advantages in many applications over other restorative materials and that significant evidence of patient risk associated with its use has not been demonstrated. Most therapeutic materials involve potential side effects or risks as well as benefits and dentists are trained to be on their guard for these reactions at all times." Council noted that, whatever the outcome of Dr. Vimy's research, the investigation will raise scrutiny within the profession and among members of the general public on the subject of mercury toxicity. Council, accordingly, agreed with Dr. Vimy's suggestion that further research is required.

RESOLVED:

87.93 THAT CDA encourage governments to fund definitive studies on the mercury toxicity of dental amalgam in restoration.

ADOPTED

DENTAL MATERIALS AND DEVICES

3. Canadian Dental Research Foundation Award

There were five excellent applications for the 1987 CDRF award. Three referees judged the submissions and clearly felt that Dr. Leonard Chumak's paper entitled "An In Vitro Investigation of Lingual Bonding" merited the award.

RESOLVED:

- 87.94 THAT Dr. Leonard Chumak be the recipient of the 1987 CDRF Award of \$2,000 for his paper on "An in Vitro Investigation of Lingual Bonding" and that the CDRF trophy be supplied to the Dean of the University of Western Ontario, Faculty of Dentistry, the location where Dr. Chumak carried out his research.

ADOPTED

Items for Information Not Requiring Board Action

4. Geriatric Dentistry

As requested by Executive Council, the Council examined the issue of how it could get involved in geriatric dentistry. It was mainly felt that, as the Council deals with products and not people, it would be difficult to take action on this topic. However, it was suggested that many of these products are used in geriatric dentistry (e.g. implants, denture marking systems, etc.) and information articles on specific products could be written for the Journal of the CDA. Members of the Council have been solicited for input on these articles for the Journal.

5. Implants

At the recent Council meeting, Dr. Lennart Malberg of Nobelpharma gave a presentation on osseointegrated implants. Council listened to this interesting presentation, but informed Dr. Malmberg that CDA could not endorse any implant system.

6. Dental Identification Systems

At the request of the Council on Health Care, the Council discussed dental i.d. systems. Council approved in principle the concept of identification systems and has requested that the Organization for International Standardization (ISO) establish standards for such systems.

DENTAL MATERIALS AND DEVICES

7. CDA/CSA Certification Program

Council has reaffirmed its intention to continue to explore the possibilities of establishing a certification/quality assurance program. A joint program with the Canadian Standards Association is no longer being considered as a result of the high costs involved. A sub-committee has been struck to explore the feasibility of a CDA-sponsored approval mechanism. Legal advice is being sought on CDA's potential liability under such a certification program. Further details will be provided in our next report to the Board.

8. Standards for Sterilizers

As a result of information provided on a certain sterilizer which was taken off the market in Canada, it was brought to Council's attention that there are no standards for sterilizers, other than electrical standards. The Council is requesting that the Canadian Standards Association develop comprehensive standards for sterilizers.

9. Status Reports

At the request of Dr. John Hardie, Chairman of the Publications Committee, members have been requested to prepare status reports on various subjects. Dr. Peter Williams has agreed to ask one of his colleagues to prepare an article on cosmetic dentistry.

Respectfully submitted,

Ralph Y. Barolet, D.D.S.
Chairman, Council on Dental
Materials and Devices

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Dental Materials and Devices with appreciation.

COUNCIL ON EDUCATION & ACCREDITATION

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. A. Schwartz, Chairman, Manitoba
Dr. G. S. Beagrie, British Columbia
Dr. M. A. Boyd, British Columbia
Dr. G. W. Burgman, Ontario
Dr. H. Dick, Alberta
Dr. B. S. Graham, Nova Scotia
Dr. H. Harder, Saskatchewan
Dr. M. Jahjah, Quebec
Dr. A. LaBounty, British Columbia
Ms. K. MacDonald, Nova Scotia
Dr. E. McIntyre, Alberta
Mrs. M. Paquin, British Columbia
Dr. K. Pownall, Ontario
Miss J. Robarts, Ontario
Dr. G. Thompson, Alberta
Dr. R. Thordarson, British Columbia
Miss P. Zakarow, Ontario (Alternate)

Dr. J. Christie, Executive Liaison, Nova Scotia

Staff: Mr. Brian Henderson, Director, Education & Accreditation
Miss Linda Teteruck, Director of Communications
Mrs. Lorraine Emmerson, Coordinator of Accreditation

Council Meeting

The Council on Education and Accreditation met on June 3 and 4, 1987 in Ottawa. Immediately preceeding this meeting, Committee No. 1 met on June 2nd and Committee No. 2 met on June 1st. The Closed Session of Council was held on the morning of June 3rd, with the remainder of the day devoted to the Open Session.

Committee No. 1 - Members

Dr. K. Pownall, Chairman, Toronto
Dr. G. Beagrie, Vancouver
Dr. M. Boyd, Vancouver
Dr. W. Burgman, Kirkland Lake
Dr. H. Dick, Edmonton
Dr. A. LaBounty, Kelowna
Dr. G. Thompson, Edmonton
Miss P. Zakarow (Alternate), London

Committee No. 2 - Members

Ms. K. MacDonald, Chairman, Halifax
Dr. B. Graham, Halifax
Dr. L. Harder*, North Battleford
Dr. M. Jahjah, Montreal
Mrs. M. Paquin, Vancouver
Miss J. Robarts, Welland
Dr. R. Thordarson, Vancouver

DAT Committee - Members

Dr. I. Bennett, Chairman, Nova Scotia
Dr. M. Boyd, Vancouver
Dr. J. Krupanszky, Toronto
Dr. A. Vaillancourt, Montreal
Dr. G. Thompson, Edmonton
Dr. J. Graham, ADA Consultant
Dr. L. Branda, Consultant, Ontario
Dr. R. Smith, ADA Director, Educational Measurements

Continuing Education Committee - Members

Dr. K. Bentley, Chairman, Montreal
Dr. G. Beagrie, Vancouver
Dr. H. Dick, Edmonton
Dr. M. Jahjah, Montreal

Committee on Documentation - Members

Dr. K. Bentley, Chairman, Montreal
Dr. M. Boyd, Vancouver
Dr. R. Brooke, London

Items Requiring Board Action

1. Recommendation to Establish a Specialty in "Orofacial Diagnostic Sciences" APP. 1

The Council on Education and Accreditation has traditionally served as a resource to the Board of Governors with respect to questions of recognition of additional dental specialties. In its report to the 1986 annual meeting of the CDA Board of Governors, Council did not support recognition of the specialty of Oral Medicine and received support from the Board to direct the Continuing Education Committee of Council to develop the concept of an umbrella discipline of diagnostic sciences within which concentrations in Oral Pathology, Oral Medicine and Oral Radiology might be possible. The Committee on Continuing Education has followed up appropriately and the paper presented to Council in response is attached as Appendix 1. Council has reviewed the paper and formally approved in principle the concept of the formation of a specialty in "Orofacial Diagnostic Sciences".

*Appointed to fill unexpired term of Dr. I. Vogan following his resignation from Council.

As instructed by Council, professional societies vitally interested in such a concept have been contacted and alerted that Council would be asking the CDA Board of Governors to consider the following motion.

RESOLVED:

87.95 THAT the CDA Board of Governors approve in principle the formation of a specialty in Orofacial Diagnostic Sciences.

TABLED**NOTE: To be reviewed by Executive Council.**

If the CDA Board endorses this resolution, the Council on Education and Accreditation will follow up appropriately by beginning development of accreditation requirements following a review of educational patterns in consultation with the ACFD, the national associations representing Oral Pathology, Oral Radiology and Oral Medicine, licensing authorities, RCDC and other appropriate authorities. The products of these further investigations would be brought back to the CDA Board of Governors for approval.

2. Requirements for Approval of a Graduate/Postgraduate Program in Pediatric Dentistry APP. 2

The Committee on Documentation has completed its revision of the document "Requirements for Approval of a Graduate/Postgraduate Program in Pediatric Dentistry", in consultation with appropriate bodies. The Council on Education and Accreditation has approved the resulting document (see Appendix 2) and requested that the document be submitted for approval of the CDA Board of Governors:

RESOLVED:

87.96 THAT the "Requirements for Approval of a Graduate/Postgraduate Program in Pediatric Dentistry" be approved by the CDA Board of Governors.

ADOPTED

3. Dental Admissions Test Committee

APP. 3

A very comprehensive report was received from the Chairman of the Committee, Dr. Ian Bennett. Recommendations from the Committee were approved by the Council and the following are presented to the Board for approval:

RESOLVED:

87.97 THAT Dr. Gordon Thompson and Dr. Judy Krupanszky be appointed to serve a second three year term on the DAT Committee.

ADOPTED

RESOLVED:

- 87.98** THAT Dr. Richard Smith, Director of the Division of Educational Measurement of the American Dental Association, or his designate, be appointed as a consultant to the DAT Committee for a one-year term.

ADOPTED

RESOLVED:

- 87.99** THAT Dr. J. Graham, American Dental Association and Dr. Luis Branda continue in the capacity of consultants to the DAT interview study for another year.

ADOPTED

RESOLVED:

- 87.100** THAT the DAT administration fee schedule be approved.

ADOPTED

The DAT administration fee schedule is attached as Appendix 3.

4. ADA/CDA Reciprocity Agreement

Members of the Board are aware of the ongoing discussion and negotiation with the American Dental Association on the subject of the reciprocal agreement to recognize graduates of accredited programs in either country for the purpose of eligibility for licensure examinations in the second country. A written agreement did not exist in the case of predoctoral education programs and the American Dental Association Commission on Accreditation had raised the concern that graduates of accredited undergraduate programs in Dentistry in the United States were being treated differently from graduates of accredited Canadian programs for the purpose of certification by the NDEB and subsequent licensure. Our Council on Education and Accreditation consistently took the position that graduates of accredited programs in either country should be eligible to write licensure examinations in the second country without the need to complete additional educational requirements. A written agreement to this effect has now been proposed by the American Dental Association Council on Dental Education and Commission on Dental Accreditation and the following motions are presented for the consideration of the CDA Board of Governors. The Board is asked to approve motions A and B and to adopt motion C.

RESOLVED:

- 87.101 (A) THAT the Council on Dental Education (CDE) of the American Dental Association (ADA) enter into a reciprocal agreement with the Council on Education and Accreditation (CEA) of the Canadian Dental Association (CDA) for the recognition by the ADA of predoctoral educational programs in dentistry accredited by the Council on Education and Accreditation (CEA) of the CDA, and be it further

RESOLVED, that the CDE of the ADA encourage certifying or licensing boards in the United States to recognize individuals who have completed successfully a predoctoral educational program of four or more academic years in length accredited by the CEA of the CDA, as eligible for written and clinical examinations for certification or licensure without further educational requirement, and be it further

RESOLVED that this agreement of reciprocity be subject to the approval of the CEA of the CDA.

APPROVED

- 87.102 (B) THAT the Commission on Dental Accreditation (CODA) of the ADA include in its listing of accredited predoctoral programs all of the accredited dental schools on the list of the CEA of the CDA, and also include the definitions of accreditation status, the current accreditation status of each predoctoral program, and the year of the next scheduled site visit, as provided to the CODA by the CEA of the CDA following each of its meetings, and be it further

RESOLVED, that the CODA and the Division of Educational Measurements of the ADA collect complete statistical information from all recognized Canadian dental schools through the Annual Survey instrument used for U.S. accredited programs, and that summary reports for Canadian predoctoral programs, similar to those developed for U.S. predoctoral programs, be published in exchange for reimbursement of direct costs by the CDA, and be it further

RESOLVED, that the CODA of the ADA formally notify the CEA of the CDA following each CODA meeting of major changes in its predoctoral accreditation standards and its accreditation policies and procedures, and also provide an updated listing of the CODA accredited programs, and be it further

RESOLVED, that the CODA of the ADA extend an invitation to representatives of the CEA of the CDA to attend its biannual meetings, appropriate ad hoc standing committee meetings, mutually agreed upon predoctoral accreditation site visits, and meetings of other ADA agencies involved with matters directly related to predoctoral dental education, and be it further

RESOLVED, that this agreement on reciprocity be subject to the approval of the CEA of the CDA.

APPROVED

- 87.103 (C) THAT the CEA of the CDA enter into a reciprocal agreement with the CDE and the CODA of the ADA for the recognition by the CDA of predoctoral educational programs in dentistry accredited by the CODA of the ADA, and be it further

RESOLVED that the CEA of the CDA encourage certifying and licensing boards in Canada to recognize individuals who have completed successfully a predoctoral educational program of four or more academic years in length accredited by the CODA of the ADA, as eligible for examination for certification or licensure without further educational requirements, and be it further

RESOLVED, that the CEA of the CDA include in its list of accredited predoctoral programs all of the accredited dental schools on the list of the CODA of the ADA, including definitions of accreditation status, the current accreditation status of each program, and the year of the next scheduled site visit, as provided by the CODA following each meeting, and be it further

RESOLVED, that the CEA of the CDA assist the CODA and the Division of Educational Measurements of the ADA in collecting statistical information from accredited Canadian dental schools through the Annual Survey, and that the CDA reimburse the ADA for the direct costs associated with conducting the Annual Survey and publishing agreed upon summary reports, and be it further

RESOLVED, that the CEA of the CDA formally notify the CODA of the ADA following each CEA meeting of major changes in its predoctoral accreditation standards, policies and procedures, and also provide an updated listing of CEA accredited programs, and be it further

RESOLVED, that the CEA of the CDA extend an invitation to representatives of the CODA of the ADA to participate in its regular meetings, appropriate ad hoc and standing committee meetings, mutually agreed upon predoctoral accreditation site visits and meetings of other CDE agencies directly involved with predoctoral dental education, and be it further

RESOLVED, that this agreement on reciprocity be subject to the approval of the CDE and the CODA of the ADA.

ADOPTED

5. Completion of the Annual ADA Survey of Schools as an Accreditation Requirement

The Commission on Dental Accreditation of the American Dental Association has specified that completion of the ADA annual survey of schools by Canadian Faculties of Dentistry is one of the essential terms included in the written agreement on reciprocal recognition of graduates of accredited programs. In the United States, completion of the ADA annual survey is a requirement specified by the accreditation process. The Council on Education and Accreditation recommends introduction of a comparable requirement in order to assure completion of the ADA annual survey by Canadian Faculties of Dentistry.

RESOLVED:

- 87.104** THAT the introduction of an accreditation requirement for the completion of the modified ADA Annual Survey of Schools be approved with the understanding that the requirement will come into force at the beginning of 1988 and that CDA will support the direct costs incurred by ADA in administering the annual survey to the Canadian Faculties of Dentistry.

ADOPTED

The American Dental Association has estimated costs involved in administration of the annual survey to Canadian schools at approximately \$5,000 U.S. per annum. An appropriate amount has been budgeted in the 1988 budget submission of the Council on Education and Accreditation.

6. Moratorium on Accreditation of Level 1 Dental Assisting Programs

The Director of Accreditation has identified a number of limitations in the ability of the accreditation process to serve as an adequate quality assurance process related to the preparation of dental assistants. Problems noted included the fact that scope of duties for dental assistants varies greatly from province to province; dentists may hire graduates of unaccredited programs or train their own assistants; there are many new private vocational programs preparing dental assistants which may or may not apply for accreditation; Dental Assisting is not a recognized category of preparation in Quebec; the CDA Board of Governors has not established a national competency profile for dental assistants that would reflect national expectations of what constitutes a dental assistant with an adequate scope of duties - the Board has supported a competency profile specifying the lowest common denominator.

Information is presented elsewhere in this report on a number of other concerns which have lead to Council's establishment of a Task Force on Future Planning which can give consideration to the quality assurance role being played by the Council on Education and Accreditation and how the Council might discharge such responsibilities, in future, in the context of finite human resources and funding. It is anticipated that the Task Force may confirm that a national certification process for dental assistants, linked to the Council, might be a more efficient and economic approach to quality assurance in the preparation of dental assistants. In the interim Council believes that further involvement in the accreditation of Level 1 (Extra-oral) dental assisting programs should not be undertaken:

RESOLVED:

- 87.105** THAT the Board of Governors approve the introduction of a one year moratorium on the accreditation of all Dental Assisting Level 1 programs, effective immediately.

ADOPTED

Items for Information - Not Requiring Board Action

7. Support for the Concept of a Commission on Accreditation

Council formally expressed its support for the establishment of a Commission on Accreditation through a recommendation approved at the Closed Session. Members expressed the opinion that the formation of a Commission would enhance the credibility of the accreditation process.

The Director of Accreditation has informed Council that this topic has been placed upon the agenda of the planning session of the CDA Executive Council to be held this fall. Council appreciates this initiative and encourages a thoughtful review of the concept of a Commission on Accreditation.

8. Establishment of a Task Force on Future Planning

The Director of Accreditation has identified a number of problems and pressures facing the accreditation process which highlight the need for future planning. Points noted included the growing volume of demand for accreditation surveys, limited resources and the limitation in the ability of the accreditation process to serve as a quality assurance mechanism in the case of the preparation of dental assistants. It was emphasized that a mechanism is required for systematic planning and to consider a number of recommendations arising from a meeting sponsored by the National Dental Examining Board of Canada to discuss concerns about accreditation as a basis for certification. Council has directed that a Task Force on Future Planning be formed, consisting of three members, with the Council Chairman and Director of Education and Accreditation as ex-officio members. Council has also directed that in future, there should be two meetings of the Council on Education and Accreditation per year to permit members to cope with the volume of material involved. The 1988 budget proposal of the Council on Education and Accreditation includes provision for the operation of such a Task Force. The Task Force will also be asked to consider an appropriate increase in the annual ACFD levy assessed each educational program (on behalf of the accreditation process) as Council is concerned that there has not been an increase in this levy for twelve years.

9. Consideration of an Accreditation Requirement Governing Students
Granted Advanced Standing

Council defeated a recommendation from the Committee on Documentation to amend the "Requirements for Approval of a Program Leading to a DDS/DMD Degree" to include a stipulation that the Director of Accreditation would be provided with a detailed accounting of credits and course requirements granted students admitted with advanced standing if the student were to be permitted to complete degree requirements in a period of less than two academic years. Members were concerned that the proposed requirement, as worded, infringed upon academic freedom and did not specify a mechanism for reviewing the credits and course requirements submitted to the Director of Accreditation. The proposed amendment to the basis of approval has been referred back to the Committee on Documentation for further consideration.

10. Resource Documents

Council granted approval to a document "Survey Questionnaire to be Submitted in Support of an Accreditation Survey for a Program Leading to a DDS/DMD Degree". A second document "CDA Accreditation Process: A Handbook of Information" was also approved as presented. Both of these documents are resources which will be useful to schools cooperating in the accreditation process.

11. Teaching Conference

Dr. Marcia Boyd has agreed to assume the chairmanship of the 1987 Teaching Conference "Conference on Strategic Planning" which will be held in either Montreal or Toronto in late 1987. The Canadian Fund for Dental Education has agreed to support this Conference with a grant of \$10,000. Dr. Boyd has requested additional funding from the Canadian Dental Association to support a total Conference budget of \$15,800.

12. Further Work on Accreditation Standards

Comments have been received and considered from ACFD, Faculties of Dentistry and interested individuals on draft documentation setting out requirements for approval of programs in each of the recognized dental specialties. It is expected that documentation related to Dental Public Health, Endodontics, Oral Radiology, Periodontics and Orthodontics will be completed in time for submission to the Interim meeting of the CDA Board of Governors. Council has granted its approval for submission of these documents with the understanding that sections on curriculum, which are incomplete at present, will be established in cooperation with the appropriate specialty societies.

13. Self-Learning/Self-Assessment Project

APP. 4

Dr. Kenneth Bentley, Chairman of Council's Committee on Continuing Education, the body responsible for coordination of the Self-Learning/Self-Assessment Project submitted a report to Council describing progress on the pilot project. This report is attached as Appendix 4.

14. Follow up on Prelicensure Conference

APP. 5

Council's Committee on Continuing Education was also given the responsibility of monitoring developments arising from the 1985 CDA Conference on Prelicensure. The Committee's report on developments is attached as Appendix 5.

15. Competency Profiles: A Status Report

The Dental Assisting Level 1 Competency Profile was approved at the Interim Board meeting in April and is available for distribution to all interested organizations. Copies may be acquired from the Accreditation Secretariat.

The Director of Accreditation is arranging to bring concerned parties together to consider a few further changes in wording of the Competency Profile for Dental Hygiene. It is hoped that a review mechanism involving representation from the Canadian Dental Hygienists Association, the Canadian Dental Assistants Association, provincial dental associations and the Council on Education and Accreditation will be able to agree upon final revisions and resubmission of the Dental Hygiene Competency Profile to the CDA Board of Governors.

16. Geriatric Dentistry

Council reviewed a request from Mr. Neilson inviting Council/Committee Chairpersons to report on ongoing activities in the area of geriatric dentistry and to present plans on potential future activities. Council members noted that curriculum in faculties of dentistry across Canada is being revised to ensure that there is appropriate emphasis on geriatric dentistry. Dr. Beagrie reported to Council that FDI has established a Working Group on Geriatric Dentistry and invited Canadian participation. The Chairman is a general practitioner from Sweden.

A meeting of the Section on Geriatric Dentistry of the ADA will be held in Winnipeg in 1988 and the International Association of Geriatric Dentistry will be participating in the 1988 CDA convention. The Curriculum Coordinators Section of the ACFD will be discussing this item at the ACFD meeting in Vancouver in June.

17. Reports

Council received reports from the following organizations with thanks:

- i National Dental Examining Board of Canada
- ii Royal College of Dentists of Canada
- iii Association of Canadian Faculties of Dentistry
- iv Canadian Dental Hygienists Association
- v Canadian Dental Assistants Association
- vi Council on Student Affairs
- vii Canadian Fund for Dental Education

18. Surveys

A list of institutions requiring surveys of their programs during the 1987-88 academic year was received and approved.

(a) Programs Surveyed 1986-87

Programs were accredited as follows:

University of Toronto DDS/DMD Program, Toronto
 Hospital for Sick Children Dental Internship, Toronto
 Mount Sinai Hospital, Dental Internship, Toronto
 St. Michael's Hospital, Dental Internship, Toronto
 Sunnybrook Medical Centre, Dental Internship, Toronto
 Toronto Western Hospital, Dental Internship, Toronto
 McGill University DDS/DMD Program, Montreal
 University of Manitoba DMD Program, Winnipeg
 University of Manitoba Oral Surgery Program, Winnipeg
 University of Montreal DDS/DMD Program, Montreal

Holland College Dental Assisting, P.E.I.
 Northern Alberta Institute of Technology Dental Assisting,
 Edmonton
 Southern Alberta Institute of Technology Dental Assisting, Calgary
 Wascana Institute of Applied Arts & Sciences Dental Assisting,
 Regina
 Okanagan College Dental Assisting, Kelowna
 Algonquin College of Applied Arts & Technology Dental Assisting,
 Ottawa
 Georgian College of Applied Arts & Technology Dental Assisting,
 Orillia
 John Abbott College Dental Hygiene, Ste Anne de Bellevue
 Cegep Saint-Hyacinthe Dental Hygiene, Saint-Hyacinthe
 Cegep François-Xavier Garneau, Quebec City
 Wascana Institute of Applied Arts & Sciences Dental Hygiene,
 Regina

Algonquin College of Applied Arts & Technology Dental Hygiene,
Ottawa
Confederation College of Applied Arts & Technology Dental
Hygiene, Thunder Bay

19. Nominations Committee Report

The following Committee membership is proposed for 1987-88.

Committee No. 1

Dr. K. Pownall, Chairman, Ontario
Dr. M. Boyd, British Columbia
Dr. W. Burgman, Ontario
Dr. A. LaBounty, British Columbia
Dr. J. Main, Ontario*
Dr. E. McIntyre, Alberta
Dr. G. Thompson, Alberta
Miss M. Shildkraut*, Student Council Representative

Committee No. 2

Ms. K. MacDonald, Chairman, Nova Scotia
Dr. H. Dick, Alberta
Dr. B. Graham, Nova Scotia
Dr. L. Harder*, Saskatchewan
Dr. M. Jahjah, Quebec
Mrs. M. Paquin, British Columbia
Miss J. Roberts*, Ontario
Registrar - to be announced*

DAT Committee

Dr. I. Bennett, Chairman, Nova Scotia
Dr. M. Boyd, British Columbia
Dr. J. Krupanszky, Ontario
Dr. A. Vaillancourt, Quebec
Dr. G. Thompson, Alberta

Documentation Committee

Dr. K. C. Bentley, Chairman, Quebec
Dr. R. I. Brooke, Ontario
Dr. M. A. Boyd, B.C.

Committee on Future Planning

Dr. R. Thordarson, Chairman, B.C.
Dr. H. Dick, Alberta
Ms. Kate MacDonald, Nova Scotia

Consultants

Dr. J. Graham, ADA
Dr. Luis Branda, Ontario
Dr. Richard Smith, ADA
Director of Educational
Measurements

Continuing Education

Dr. K. C. Bentley, Chairman,
Quebec
Dr. G. S. Beagrie, B.C.
Dr. M. Jahjah, Quebec
Dr. H. Dick, Alberta

*indicates current nominations

20. SUMMARY

Council continues to recognize and carry out its responsibilities related to Education and Accreditation. Council notes with regret that Dr. George Beagrie, Dr. Roy Thordarson and Dr. Pamela Zakarow will be leaving Council at the end of this term and expresses thanks and appreciation to each.

I would also like to express appreciation for the tremendous efforts of Mr. Brian Henderson, Director of Education and Accreditation and Mrs. Lorraine Emmerson, Coordinator of Accreditation in the face of a record volume of material over the past year and their admirable success in coping with it within the constraints of time and resources available.

Respectfully submitted,

Dr. Arthur Schwartz, Chairman
Council on Education and
Accreditation

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Education and Accreditation with appreciation.

Appreciation is extended to Mr. Brian Henderson for his outstanding achievement, particularly in the area of the ADA/CDA Reciprocity Agreement.

PROPOSAL TO ESTABLISH AN "UMBRELLA" SPECIALTY OF
OROFACIAL DIAGNOSTIC SCIENCES

Background

At the present time the Specialties of Oral Pathology and Oral Radiology are recognized by the Canadian Dental Association. For several years, along with growth in the discipline of Oral Medicine, there has been pressure from its practitioners for recognition of Oral Medicine as a third distinct specialty in the general field of orofacial diagnostic sciences.

Recently, a joint proposal from the American Academies of Oral Medicine and Oral Radiology, together with the organization of teachers of oral diagnosis, suggested the formation of an umbrella specialty which would incorporate Oral Medicine, Oral Radiology and Oral Pathology. This proposal was rejected by the Academy of Oral Pathology in a response which cited the specialty's "superior record of competency as a specialty, the existence of no expertise over and above our own clinical diagnosis, plus our laboratory and histopathology diagnosis expertise, loss of control of our certifying board and the jeopardy of our Association with the American College of Pathologists...". The response also pointed out that many individuals involved with radiology and diagnosis are "general practitioners who are not specially committed and that all the recognized specialties and general dentists practice various aspects of oral medicine".

Grounds for Reconsideration

The response by the Academy of Oral Pathology does not provide grounds for the rejection of the concept of an umbrella specialty of Orofacial Diagnostic Sciences. The specialty of Oral Radiology, for example, already exists in Canada and contradicts the Academy's assertion that there is "no expertise over and above our own clinical diagnosis". The comments about loss of control of the Certifying Board and the jeopardy of the Association with the American College of Pathologists do not pertain in Canada. Finally the concerns that "many involved in these organizations are general practitioners who are not specially committed" and "that all the recognized specialties and general dentists practice various aspects of oral medicine" are surely not arguments against establishment of a specialty. The same concerns might be expressed of medicine and surgery which are also practiced by general practitioners in medicine.

More important, there are a number of additional arguments for the establishment of an umbrella specialty of Orofacial Diagnostic Sciences in Canada. There are a limited number of practitioners in Oral Pathology, Oral Radiology, and Oral Medicine. Collectively, within an umbrella specialty, the individual groups could both retain responsibility for their individual areas of interest and benefit from the association with the larger entity.

The dental profession as a whole has cause to be concerned about the potential for increasing fragmentation and unwarranted growth of new specialties. The field of Prosthodontics, and related developments in the United States illustrate the fragmentation of this discipline into sub-specialties and its reintegration as an umbrella specialty.

Studies concerned with future trends in dentistry have suggested that there will be an increased need for and emphasis on diagnostic sciences in dentistry within a few years. Recognition of an umbrella specialty of Orofacial Diagnostic Sciences could assist educational programs to respond to this need by providing the structure for an integrated approach and the growth and development of resources comprehensive enough to respond to developing needs.

Inclusion of Oral Medicine within the Proposed Umbrella Specialty

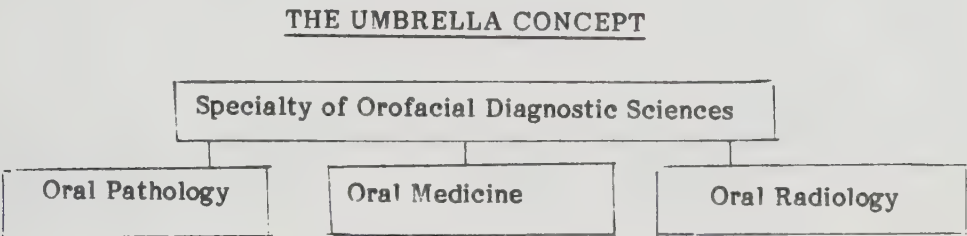
Oral medicine may be defined as "the diagnosis and treatment of non-surgical conditions of the mouth and associated structures which may be localized to the mouth or may be a manifestation of systemic disease".

One reason that Oral Medicine has encountered difficulty in obtaining recognition has been the concern of the dental profession to avoid increased fragmentation and endless growth of new sub-specialties. Recognition of the discipline of Oral Medicine within the umbrella specialty of Orofacial Diagnostic Sciences should provide an adequate response to this concern.

A second obstacle has been the position of the Canadian Academy of Oral Pathology. The Canadian Academy of Oral Pathology has asserted that the subject of oral medicine is currently contained within the definition of Oral Pathology in Canada and that many oral pathologists devote a substantial part of their time to this practice. It is noted, however, that in some graduate programs in Oral Pathology there has been very little emphasis on clinical work. Conversely, a body of practitioners specifically trained to practice oral medicine exists in Canada and it would seem reasonable to recognize this fact and include Oral Medicine along with Oral Radiology and Oral Pathology within the umbrella specialty of Orofacial Diagnostic Sciences.

The Concept of an Umbrella Specialty of Orofacial Diagnostic Sciences

The following diagram illustrates the basic elements of the concept of an umbrella specialty with three disciplines to be recognized for endorsement within that specialty:



The recognized specialty would be "Orofacial Diagnostic Sciences". An individual might be formally endorsed in one or more of the three included disciplines, depending upon educational qualification.

Related Educational Patterns

Educational programs intended to prepare specialists in Orofacial Diagnostic Sciences might be structured in several ways. Two basic alternatives can be identified as starting points for discussion.

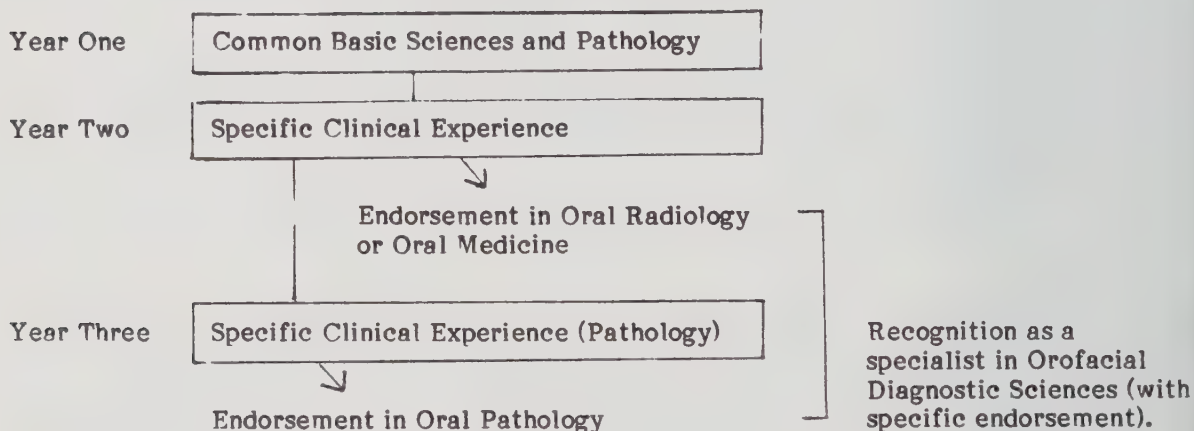
1. Model With One Common Year

It would be possible to establish a first year educational program common to all three disciplines. This might consist of the basic science subjects of anatomy, physiology, biochemistry, etc. and pathology.

A second year could be devoted to clinical work required for preparation in one discipline.

At the end of the second year, an individual who had followed the appropriate clinical stream could graduate with an endorsement in Oral Medicine or Oral Radiology. An individual seeking an endorsement in Oral Pathology would be required to complete an additional year of clinical experience in this discipline. This educational pattern is illustrated in the following diagram.

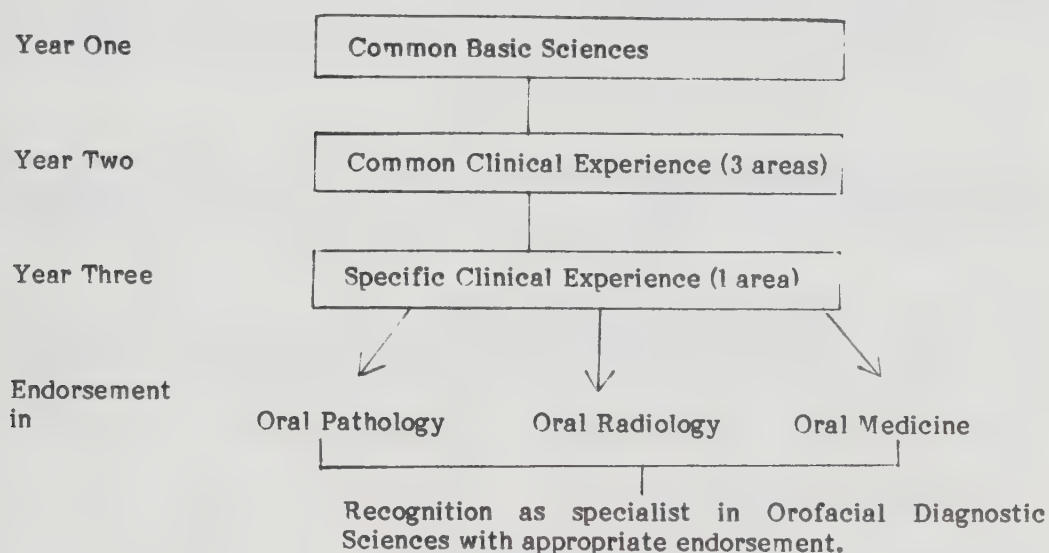
MODEL WITH ONE COMMON YEAR



2. Model With Two Common Years

Alternatively, a new educational pattern might be introduced which would require a common first year in basic sciences, a common second year of clinical experience touching all three disciplines to some extent and a third year in which additional specific clinical experience in one discipline was provided. Such an educational pattern is illustrated in the following diagram:

MODEL WITH TWO COMMON YEARS



CONCLUSIONS

The Canadian Dental Association Council on Education and Accreditation should be invited to support the recognition of the specialty of Orofacial Diagnostic Sciences with endorsements in Oral Pathology, Oral Radiology, or Oral Medicine, and to make an appropriate recommendation to the CDA Board of Governors. If approved in principle by the CDA Board of Governors, the Canadian Dental Association Council on Education and Accreditation should determine accreditation requirements following review of educational patterns in consultation with the ACFD, the national associations representing Oral Pathology, Oral Radiology and Oral Medicine, licensing authorities, RCDC and other appropriate authorities.

Committee on Documentation
May, 1987

REQUIREMENTS FOR APPROVAL OF A GRADUATE/POSTGRADUATE PROGRAM IN PEDIATRIC DENTISTRY

The Council on Education and Accreditation of the Canadian Dental Association is dedicated to the objective of developing and improving graduate/postgraduate education in the dental specialties in Canada to the highest possible level. The Council on Education and Accreditation reaffirms that in conducting evaluation surveys its prime purpose is to assist, stimulate and recommend methods and procedures that enable sponsoring institutions to improve the effectiveness of their programs. To this end Council considers the encouragement of sound educational experimentation and innovation to be an integral part of its accrediting responsibility. It is not Council's intention to impose a system of regimentation which would lead to the standardization of educational programs in the specialty areas in Canadian dental schools.

This document delineates the minimum requirements for approval of a graduate/postgraduate program in Pediatric Dentistry. These requirements must be met for a program to be approved by the Council on Education and Accreditation.

In addition, Council may undertake studies related to improvement of the accreditation process. These studies will require the provision of additional information by institutions being surveyed. Council expects the institutions to co-operate in these studies. Although not forming part of the minimum requirements at the time, the results of such studies may form the basis for the introduction of new minimum requirements in that area.

I. Definition of Terms

Must; Shall; Council expects; It is expected;

These words or phrases indicate a requirement that is essential or mandatory.

Should:

This word implies that a recommendation is highly desirable.

May or Could:

These words imply freedom or liberty to follow a suggested alternative.

Graduate Program:

One in which administrative responsibility for the program resides in the university's school of graduate studies.

I. Definition of Terms (cont'd.)

Postgraduate Program:

A planned sequence of courses, offered at universities, dental schools, associated teaching hospitals and/or other similar institutions designed to provide advanced educational experience, the successful completion of which is recognized by a diploma or certificate. Where institutional policy permits, it may lead to a degree in a professional field, e.g., Master of Dental Science or some similar designation, or it may form part of a more extensive program leading to a degree.

II. Pediatric Dentistry

Pediatric Dentistry is the practice and teaching of comprehensive preventive and therapeutic oral health care for children from birth through adolescence. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate medical, physical and/or emotional problems.

A pediatric dentist is a dentist who is specially trained to provide comprehensive oral health services for pediatric and adolescent age groups as well as for medically, physically and/or emotionally compromised patients.

A pediatric dentist must have the ability, knowledge and skill:

- 1) to provide comprehensive dental diagnostic services and comprehensive oral health services including taking, processing and interpreting radiographs;
- 2) to diagnose and treat problems related to the growth and development of the stomatognathic system;
- 3) to evaluate the general medical status of any patient and to refer if necessary for further evaluation;
- 4) to understand the behavior of both the patient and the parents and the methods of achieving and maintaining optimum oral health;
- 5) to provide restorative dental treatment in primary and permanent teeth including treatment of pulp pathosis;
- 6) to utilize the appropriate dental materials and pharmacologic agents to treat or prevent oral and dental disease;
- 7) to manage anxiety and pain in patients, including those undergoing general anesthesia in conjunction with dental procedures performed in the hospital operating room or in a comparable facility;
- 8) to treat patients in the hospital environment using accepted hospital protocol;
- 9) to evaluate critically the scientific literature in order to contribute to continuing competency in pediatric dentistry
- 10) to manage medical emergencies and use cardiopulmonary resuscitation when appropriate;

III. Scope and Duration of Educational Program

An educational program in Pediatric Dentistry must produce a specialist competent in the prevention and management of both common and unusual orofacial health problems that occur in any child or adolescent during the period of growth and development or in the emotionally, physically or mentally compromised person.

The educational program must stimulate the student's desire to be creative, to acquire new skills and to develop innovations in Pediatric Dentistry. It should encourage the development of that critical and inquiring attitude which is necessary for the advancement of practice, research and teaching in Pediatric Dentistry. The program must educate future pediatric dentists to work in coordination with members of other health and social disciplines.

Whether the educational program is designated as a graduate or as a postgraduate program, the successful completion of the curriculum must require a minimum of two academic years. Programs that have a substantive research component sufficient for the preparation and defence of a thesis will usually require additional time to ensure clinical competence.

A student may be enrolled on a part-time basis provided that: the student enrolled on a part-time basis must be continuously enrolled and must complete the total curriculum in a period of time not to exceed twice the duration of the program for full-time students.

It is the candidate's responsibility to determine and to meet the licensure and specialty recognition requirements for the region in which the candidate plans to practice.

IV. Areas To Be Assessed

(a) Program Goals & Objectives

Program self evaluation must be carried out on a periodic basis to determine if stated goals and objectives pertinent in the light of changing patterns of dental disease and dental practice are being met.

(b) Other Areas to be Assessed

The following areas will be assessed as they pertain to the stated program goals and objectives:

1. Institutional Relationships
2. Administration and Support
3. Physical Facilities
4. Faculty and Faculty Development
5. Research and Scholarly Activity
6. Admission Standards
7. Curriculum
8. Evaluation Procedures

9. Clinic Administration
10. Preparation for Clinical Practice
11. Learning Resources
12. Student Affairs
13. Relationships with DDS/DMD and other Health Science Programs, Graduate/Postgraduate Programs, and Dental Auxiliary Programs
14. Relationships with Hospitals and other Health Care Facilities
15. Relationships with Health Departments and Community Service Programs
16. Relationships with Continuing Education Programs
17. Relationships with Dental Organizations and Licensing Bodies

1. Institutional Relationships

An advanced or dental specialty education program must be sponsored by a university which is properly chartered and licensed to operate and offer instruction leading to a degree, diploma or certificate. All other educational programs offered by the university eligible for accreditation by the Canadian Dental Association must be accredited. A hospital that provides a major component of an advanced dental education program must have its dental service accredited by the Council on Hospital and Institutional Services of the Canadian Dental Association. The hospital must also be affiliated with the respective university and a formal contract of affiliation should exist between university and hospital.

2. Administration and Support

Of particular interest to Council is the adequacy of the available financial support and management relative to the program's objectives. Administration and support staff must also be adequate. The continuity of this support must be demonstrated to ensure ongoing quality instruction and effective management. The parent institution should view, in a practical manner, the unique costs involved in dental education. The cost of dental clinic operations should be recognized by the university to be educational and, as such, not necessarily totally supported by clinic revenue.

When an affiliated institution is utilized for a part of the program the university is responsible for ensuring that educational objectives are achieved.

The sponsoring university's responsibility includes, but is not limited to, assuring an administrative system which is dedicated to education. Faculty of the program must be involved in selection of candidates, program planning and ongoing program review and evaluation.

The program should be a recognized entity within the university's administrative structure. The position of the program in the administrative structure should be consistent with that of other parallel programs and the administrator should have authority, responsibility and privileges comparable to those of other program administrators.

The educational mission must not be compromised by a reliance on students to fulfill institutional service, teaching or research obligations. Resources and time must be provided for the proper achievement of educational objectives.

Some student support through stipends, tuition remission, graduate assistant appointments or scholarships is desirable.

Universities sponsoring advanced or dental specialty programs must provide financial support which will assure fulfillment of program objectives and accreditation requirements on a continuing basis. The budget should provide sufficient resources for innovations and changes which reflect current concepts of higher education and new developments in the practice of the specialty.

3. Physical Facilities

In surveying a program Council will examine the type of building, the equipment of the classrooms, laboratories, clinical, hospital and institutional facilities, and the general condition in which these are found. These will be viewed in light of current concepts and philosophies of dental practice and education. These facilities must permit effective attainment of the program objectives.

Space should be designated specifically for the program and the facilities should be supplied with modern equipment and instruments. Adequate radiographic and laboratory facilities must be available and in reasonable proximity to the patient treatment area. Students should be able to carry out part of their education in the hospital out-patient dental clinic, on the ward and in the operating room.

Where graduate/postgraduate programs are conducted at institutions which also have other programs it is expected that the demands for classroom, laboratory, seminar, library, clinical and other facilities will not compromise any individual program.

The design and construction of radiography facilities must provide adequate protection from ionizing radiation for patient, operator and others in close proximity. The institution must ensure that it is in compliance with provincial and federal regulations relating to radiation protection as delineated in the Guidelines for the Control of Radiation in the Dental Office* as developed by the Council on Health Care of the Canadian Dental Association. Where provincial or federal regulations are not in force it is the institution's responsibility to undertake inspection to ensure operation within safe parameters. There should be adequate space for students to mount, view and evaluate radiographs.

* Appendix I

4. Faculty and Faculty Development

Both basic science and clinical faculty must have qualifications appropriate to their field of instruction. Such qualifications should include completion of advanced education programs, extensive clinical and/or teaching experience, research and other scholarly productivity, and peer recognition. A significant number of clinical staff should be certified specialists or possess comparable qualifications. The director of the program should possess advanced education in pediatric dentistry to qualify for a membership or fellowship in the Royal College of Dentists of Canada. Ideally the director should be a full-time faculty member as defined by the university.

Graduate/Postgraduate education must encourage independent study by the student. Continuous close supervision by the faculty is neither necessary nor desirable. However, it is expected that the faculty will be available to provide adequate supervision and guidance as the student requires. For this reason an adequate proportion of the faculty in Pediatric Dentistry should be full-time and be readily accessible to the student. Graduate/Postgraduate programs must have at least one full-time faculty member who has advanced qualifications in pediatric dentistry comparable to those necessary for recognition as a specialist in the province in which the program is offered. Such an individual may also carry some teaching or administrative responsibilities outside the specialty education program.

Student-teacher ratios must be adequate to meet the stated objectives of the program. Similarly the number of full-time faculty must be adequate to meet program requirements.

The relationship between and among individual faculty members and between faculty primarily engaged in research and teaching and those primarily engaged in administration must be such as to ensure the quality of the program.

The general and professional education of the faculty, their preparation and experience for clinical practice, teaching and research and their productive scholarship must be adequate to meet the stated objectives of the program. The number of faculty, teaching loads and administrative responsibilities will be examined in this context. The mechanism for appointment, review, reappointment and promotion of faculty members, including those with administrative positions, will be studied. Remuneration and benefits, tenure and job security and methods for merit recognition will also be examined.

Responsibilities and privileges should be clearly defined and be made known to the faculty.

It is recognized that teaching in itself is a profession and professional education at the university level demands qualified persons who devote their careers to teaching and research. Appropriately qualified active practitioners also bring to the program a service and viewpoint which is essential and an

appropriate number of such individuals must participate in the teaching program.

A mechanism should be in place for ongoing peer review and the evaluation of teaching effectiveness.

The faculty, both full-time and part-time, must be involved in continuing their professional development, including continuing education in their own or related disciplines, as well as in-service and other training opportunities in order to develop increased expertise in their teaching, research and administrative roles as faculty members.

The Director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program. In addition, it is the Director's responsibility to assure that students completing the program have achieved the standards of performance established for the program and for practice in the specialty.

The program faculty should have a strong interest in teaching and be willing to contribute the necessary time and effort to the educational program. A major portion of the specialty instruction and the supervision must be conducted by individuals who are educationally qualified in the discipline. In addition individuals who provide instruction and supervision specific to other specialty areas must be educationally qualified in their respective specialties.

5. Research and Scholarly Activity

There must be an appropriate commitment to research activity by the faculty teaching in the pediatric dentistry program. This responsibility should also involve students and should have the support of the parent university with respect to finances and facilities. An appropriate balance of faculty involvement between teaching and research must exist so that the quality of the program in pediatric dentistry is not compromised. Investigations leading to the improvement of the educational program should be included in such research activities.

Council believes that there are many worthy research projects, particularly of a clinical or educational nature, which could be undertaken without major funding from external agencies.

6. Admission Standards

Admission must be based on specific selection criteria which must be defined and be readily available to advisors and applicants. Academic performance should not be the sole criterion. Admissions committees should consider non-academic criteria in the over-all assessment of applicants for admission.

Candidates should be graduates from approved dental schools in Canada or the United States or possess the equivalent educational background. The applicant's academic standing must be such that it gives reasonable assurance

of the successful completion of the program. It is suggested that several means be used to evaluate the applicant's qualifications. Among these are personal recommendations, interviews, national board results, academic records and, in the case of graduates whose primary language is not the one of instruction of the institution, a language proficiency examination should be considered.

The university should have a stated policy concerning admission of advanced standing or transfer students and copies of this policy should be readily available.

It is recognized that students may transfer, with credit, from one accredited program to another, for a variety of reasons. An accredited program accepting such a transfer student must also clearly recognize an obligation to ensure that the student completes overall didactic and clinical preparation required. Programs must be able to demonstrate how they are assured that no aspect of clinical preparation, in particular, has been omitted or insufficiently emphasized.

7. Curriculum

Council will examine the curriculum with reference to the stated objectives of the program, what it seeks to accomplish for the student, the profession and the public and its success in realizing these objectives. It is the responsibility of the Institution to maintain under continuing review and amendment the curriculum of the graduate/postgraduate program in Pediatric Dentistry. Council expects not only a well balanced curriculum but also one which recognizes changing patterns in the prevalence of dental disease, as well as in dental practice, through appropriately placed changes in specific areas of the graduate/postgraduate program in Pediatric Dentistry.

By definition, a graduate/postgraduate program provides advanced education experience beyond the undergraduate level. It is expected therefore that courses will be taught at a greater depth and breadth than in the undergraduate curriculum. Where required for the purpose of improving the student's general background, a minimum number of undergraduate courses may be permitted as part of the program. Since graduate/postgraduate programs must emphasize independent study, the number of required formal courses should not be so excessive as to preclude the candidate from undertaking library work and other independent study.

Basic Sciences:

Instruction in the basic sciences must:

- 1) provide comprehension in greater scope and depth than achieved in undergraduate education with particular emphasis on fundamental principles and recent advances

- 2) emphasize the interrelationships among the basic sciences and to correlate them with clinical practice
- 3) develop the capacity for objective analysis and critical evaluation of scientific information.

Clinical Sciences:

Instruction in the clinical sciences must:

- 1) enhance the candidate's diagnostic acumen and clinical judgment in the diagnosis and planning of treatment for conditions more complex than those encountered in the undergraduate experience
- 2) provide advanced clinical experience beyond that usually required of the general practitioner in the management of conditions appropriate to the field of specialization
- 3) emphasize the need for basing clinical judgments on objective criteria in order to avoid any tendency toward unnecessary empiricism or dogmatism
- 4) ensure that treatment in the field of specialization is appropriately related to the dental and general needs of the patient.

Although the basic sciences are taught in the undergraduate years, they are developing so rapidly that the student should be made aware of recent advances in order to understand better the biologic fundamentals of dental practice.

Basic science instruction should be designed to be relevant to the specialty discipline and to the clinical management of the patient. The clinical program should include a variety of clinical experiences. Emphasis must be placed upon thoroughness of patient evaluation and accuracy in diagnosis. Experience should be acquired in the treatment of both routine and complex cases.

Consultation with teachers of other specialty areas of dental practice and offering of joint seminars should be encouraged. Assignment of students to other graduate/postgraduate clinics should be fostered so that they may observe modes of treatment related to their field. Observation of faculty in the private practice setting is desirable.

Participation in teaching is a learning experience for the student as it enhances the ability to organize and evaluate material and communicate information to others. The student should be assigned to teach in the institution's programs and also encouraged to participate in table clinics, demonstrations or lectures before dental society meetings and study clubs. Participation as both clinician and student in the institution's continuing education program is also recommended. Other continuing education experiences are encouraged.

The program must ensure that the student participates in a research experience. The disciplined analysis involved in a clinical or laboratory research experience can be highly rewarding and can stimulate the intellectual curiosity of the student. While not every institution is prepared to offer extensive research facilities, a research experience need not be elaborate.

The program must also ensure that the student is able to prepare a scientific paper suitable for publication in a refereed journal.

The following list, although not exhaustive, represents those subjects which Council expects to find in an acceptable program. These subjects may be present with varying degrees of emphasis and need not necessarily be identified by specific course title or name:

A. Didactic - Biomedical Sciences

Biochemistry
Embryology and Genetics
Growth and Development
Head and Neck Anatomy
Microbiology and Immunology
Microscopic Anatomy
Neuroanatomy
Pathology - General
Oral
Pharmacology and Therapeutics
Physiology

B. Didactic - Preparation for Paediatric Dentistry

Principles of child behavior
Management of behavioral problems
Craniofacial growth and development
Biomechanics to correct abnormalities
Biostatistics and Research Methodology
Pediatric medicine
Clinical Pharmacology
Radiation Hygiene
Cardiology
Periodontology
Communication development and disorders.
Practice management

C. Didactic - Complementary Course Material

Anxiety and Pain Control
Behavioral Sciences
Biostatistics and Research Methodology
Dental Biomaterials Science
Diagnosis and Physical Evaluation including recognition of possible child abuse
Hospital Protocol
Jurisprudence and Medicolegal Ethics

Didactic - Complementary Course Material (cont'd.)

Literature Review and Scientific Writing

Management of Medically Compromised Patients

Medical Emergencies

Nutrition

Oncology

Related Dental Specialties

Teaching Methodology

Teaching of Pediatric Dentistry

D. Clinical Program

The special knowledge and skills and the critical judgment required of a Pediatric dentist necessitate extensive clinical practice. The clinical material must be of sufficient quantity and variety to provide the broad range of learning experiences essential to the Pediatric dentist's education and training. The student must work cooperatively with consultants and clinicians in other dental specialties and health fields. Clinical experience must be provided to develop competency in the following areas:

- 1) Comprehensive oral health care for children, adolescents, and medically, physically, and/or emotionally compromised individuals
- 2) Patient management using non-pharmacological and pharmacological approaches
- 3) Application of preventive practices including prenatal and postnatal counselling
- 4) Diagnosis and management of abnormalities in the developing occlusion
- 5) Management of dental traumatic injuries
- 6) Recognition and management of oral diseases including orofacial abnormalities
- 7) Physical evaluation of patients
- 8) In-hospital oral health care for patients
- 9) Provision of dental services for patients with the aid of general anesthesia in a hospital operating room or comparable setting
- 10) Assisting in the management of anaesthetic emergencies
- 11) Taking, processing and interpreting radiographs
- 12) Presentation of the treatment plan
- 13) Immediate and long term post treatment evaluation of the management of the patient
- 14) Use and management of auxiliary personnel

E. Hospital Experience

Students must develop the expertise in the management of sick, chronically ill and disabled persons with medical and oral disease problems. The specialist in pediatric dentistry must have sufficient hospital experience to acquire adequate knowledge and skills to function as a health care provider within the hospital setting. This would include the care of inpatients and the treatment of patients in a hospital operating room. The program must

include an anaesthesia rotation of at least four weeks duration. Pediatric medicine and emergency room rotations are desirable. The student should participate in hospital interdisciplinary evaluation and treatment teams.

F. Teaching Experience

A student can acquire deeper insights into a subject when given the opportunity to teach. Reviewing concepts, explaining a procedure or demonstrating the use of an instrument expands that concept or procedure for the teacher. Teaching also offers an opportunity to learn and apply the principles of interpersonal relations. Teaching must, therefore, be a part of the program.

- 1) Supervised Teaching: The student should be given the opportunity to spend some time in supervised teaching, preferably during the second year of studies. Not more than 10 percent of the total program time should be devoted to teaching.
- 2) Principles of Education: The student participating in teaching activities should be prepared for such activities by instruction in the principles of education.
- 3) Faculty Involvement in Teaching: The major responsibilities of carrying out the departmental clinical teaching program must not be left entirely to advanced students. The educational value of this experience is dependent upon the involvement of the faculty. Faculty must be in regular attendance during clinic sessions for supervision and instruction.

G. Elective Experience

Time should be available for elective experiences which are designed to broaden the student's background, sharpen intellect for critical analysis and provide an opportunity to gain knowledge in areas of specific interest. The student may be guided in the selection of an appropriate elective experience but the assignment of specific courses in the elective portion of the curriculum should be discouraged.

H. Extramural Experience

As part of preparing the pediatric dentist for a role in the community, the educational program should include services performed at the community level. Experiences could take the form of an outreach program designed to make dental services and education available to groups who have been previously unable to obtain such services.

8. Evaluation Procedures

(a) Student Evaluation

An effective and valid system of student evaluation must exist and be applied. Understandably these systems and techniques will vary from program to program. However, Council must be satisfied that these systems accurately establish the basis for judgments which will govern the promotion or graduation of the student concerned.

(b) Patient Care Evaluation

Clinical objectives, competency standards and evaluation procedures must be defined. These procedures must include the evaluation of the treatment process as well as the product of such treatment. Faculty supervision must be adequate to ensure that acceptable patient care standards are maintained.

Members of the clinical staff and students must participate in some form of clinical appraisal or dental audit on a regular basis.

(c) Patient Record Evaluation

Students must be evaluated on the accuracy and completeness of their record keeping. The patient record system will vary according to the dental specialty.

The patient record system must include together with appropriate dates, signature and authorizations, medical and dental histories, results of examinations, diagnostic aids, record of cumulative radiographic procedures, consultations, diagnosis/problem list, integrated and comprehensive treatment planning (including estimated fee) details of treatment rendered, cost, completion, review and follow-up procedures.

9. Clinic Administration

The clinical records must be sufficiently comprehensive for teaching purposes. Appropriate follow-up of patients for longitudinal studies must be carried out and adequate records must be kept so that evaluation of therapeutic procedures is possible.

Equipment and supplies for use in managing medical emergencies must be readily accessible and functional. The use of ionizing radiation, nitrous oxide, mercury, drugs and other substances and techniques that might be hazardous to students, patients, staff and faculty must be judiciously and carefully monitored. Adequate measures must be in place to prevent the transmission of infection.

Policies and/or protocols must exist relating to the following:

- 1) Audit of Patient Care
- 2) Collection of Patient Fees
- 3) Consultative Protocols
- 4) Fire and Safety Procedures
- 5) Medical Emergency Procedures

- 6) Patient Follow-up for Longitudinal Studies
- 7) Patient Assignment
- 8) Patient Recall
- 9) Patient Records
- 10) Development, Approval and Revision of Patient Treatment Plan
- 11) Prevention of Disease Transmission
- 12) Professional Decorum
- 13) Technical Laboratory Support

Such policies and protocols must be available for the students, staff and faculty.

While in certain circumstances students may be required to provide some supplies, equipment and patients, teaching clinics must provide sufficient support staff, supplies, equipment and patients for the adequate teaching of the Pediatric Dentistry program. In addition, necessary funding for the maintenance and updating of the clinic and eventual replacement of major equipment items must also be ensured.

Effective working relationships between the Program Director, the Clinic Director or comparable appointee and other administrators are essential. The Program Director must have access to relevant faculty policy and decision-making groups and should have appropriate committee appointments. The Program Director must establish and maintain effective working relationships with the administrators of pertinent affiliated institutions.

10. Preparation for Clinical Practice

A graduate of the program must be capable of meeting the dental health needs of the public as a practitioner of the specialty of Pediatric Dentistry. The student must be provided with sufficient opportunity for development of proficiency in the specialty of Pediatric Dentistry. There must be a sufficient supply of patients requiring a wide variety of Pediatric Dentistry services in order to provide adequate clinical experience. Treatment of disadvantaged patients should also be included. Patient assignments must provide adequate clinical experience. Accordingly the student must be capable of the development and implementation of an integrated treatment plan for comprehensive patient care including consultation with dental specialists as required. Clinical experience must be such as to produce a graduate who can safely and competently render those services usually provided in the practice of Pediatric Dentistry.

11. Learning Resources

The library is viewed as an important learning centre in the educational program. It must, whether established separately or within a combined library, be professionally administered and well housed. It should be convenient and accessible to both students and faculty during and after scheduled hours of instruction. Reference material should be readily available for students. In addition, in the clinic or the laboratory, selected reference material should be readily available for students. The staff of the resource centre must be sensitive

and responsive to the teaching and research activities of the program. Council encourages expanded development and use of audiovisual material and modern techniques of information processing and retrieval. It further encourages the faculty and the learning resources staff to promote student, staff and faculty awareness of the materials available for their use. In addition these resources should be available to the alumni and the profession at large.

12. Student Affairs

Accurate information on fees, special charges, scheduling and evaluation procedures must be made available. Records of student progress and accomplishments must be accurately maintained and treated as confidential information. Adequate measures must be in place to ensure fair judgment of the student's achievements relative to requirements for successful completion of the program.

Basic financial support and supplementary support for special activities such as research, scientific conferences and continuing education courses are desirable.

At regular intervals students should be afforded an opportunity for expression of opinion regarding the program and the instruction received.

13. Relationships with DDS/DMD Programs and Other Health Science Programs, Graduate/Postgraduate Programs and Dental Auxiliary Programs

Activities that are mutually beneficial to the program in Pediatric Dentistry and the DDS/DMD program and/or other health science programs may be developed and are encouraged.

Mutually beneficial activities between and among graduate/postgraduate programs should be encouraged. Joint participation in selected basic science and clinical courses in such cases is encouraged. The joint management of patients is expected, where appropriate.

To the extent that mutually beneficial activities can be developed, it is appropriate for co-operation to take place between programs in pediatric dentistry and dental auxiliary programs.

14. Relationships with Hospitals and Other Health Care Facilities

Because of the growing impact of hospital and institutional dentistry the program should provide opportunity for appropriate student experience in such settings. Dental Services of Hospitals utilized in advanced educational programs must be approved by the Council on Hospital and Institutional Services of the Canadian Dental Association.

15. Relationships with Health Departments and Community Service Programs

Co-operation with health departments and community service programs should be sought to provide the student with an orientation to delivery of health care in the community, especially for groups with special needs such as disabled and medically compromised patients.

16. Relationships with Continuing Education Programs

Participation of students in pertinent continuing education programs is an excellent means of providing current knowledge in concentrated form. The development and presentation of material in continuing education courses should be an integral part of the preparation of the student for service to the profession and a possible academic career.

17. Relationships with Dental Organizations and Licensing Bodies

Clinical faculty should be licensed in the province in which the program is located. Membership and participation in local, provincial and national organizations by faculty members should be encouraged as an example to students, an obligation to professionalism and an opportunity for information exchange. Student participation should also be encouraged as an active learning experience.

DENTAL ATTITUDE TEST PROGRAM

ADMINISTRATION FEE SCHEDULE

(a) TEST ADMINISTRATORS, ASSISTANT ADMINISTRATORS, PROCTORS

Number of Candidates	Test Administrator #-----\$	Sub- Total	Asst. Admin. #-----\$	Sub- Total	Proctors #-----\$	Sub- Total	Total #-----\$
1 - 9	1 @ 75	75	-	-	-	-	1 75
10 - 25	1 @ 80	80	-	-	1 @ 55	55	2 135
26 - 50	1 @ 90	90	-	-	2 @ 55	110	3 200
51 - 75	1 @ 100	100	1 @ 75	75	3 @ 55	165	5 340
76 - 100	1 @ 120	120	1 @ 75	75	4 @ 55	220	6 415
101 - 125	1 @ 140	140	2 @ 75	150	5 @ 55	275	8 565
126 - 150	1 @ 160	160	2 @ 75	150	6 @ 55	330	9 640
151 - 175	1 @ 180	180	3 @ 75	225	7 @ 55	385	11 790
176 - 200	1 @ 200	200	3 @ 75	225	8 @ 55	440	12 865
201 or more	1 @ 220	220	4 @ 75	300	9 @ 55	495	14 1015

REPORT ON THE SELF-LEARNING/SELF-ASSESSMENT PROJECT

Phase I of the Self-Learning/Self-Assessment project has been completed. The objective was to produce an examination which would permit individual dentists to evaluate knowledge of current topics important in the clinical context and to identify specific learning resources which could be employed to remedy areas of weakness. The process employed in accomplishing this objective is illustrated in the timetable which was established for the process and which was followed fairly closely:

April-May/86	Request to Universities for sample questions, answers and literature references for pilot project.
April/86	Request to C.F.D.E. for financial support pending CDA Board approval.
June/86	Selection of test items
August 1986	Request for funds from CDA Board
Sept. 1986	Letter canvassing random sampling of practitioners for participation.
Oct. 1986	Replies back from practitioners
Mid-October 1986	Questionnaire - Part I of program mailed to participants.
Mid-Nov./86	Return of Part I of program
End Dec./86	Analysis of replies mailed to participants.

The Coordinating Committee is currently working on Phase II, which will conclude the analysis of replies mailed to participants, preparation and mailing of a post-test (assessing success with learning resources provided) and analysis and follow up on Part II results.

Statistics on actual participation in the first phase of the project are presented in Appendix 1. Budget for the overall project is presented in Appendix 2.

While the project, at this point in time, is not complete, correspondence received and comments on it indicate that the pilot has been successful. A file of correspondence related to the project is available for review. The Council on Education and Accreditation, through the CDA Board of Governors, should consequently support the establishment of an on-going co-operative mechanism to be responsible for the development and administration of periodic self-learning/self-assessment examinations in future.

Respectfully submitted,

Kenneth C. Bentley, Chairman,
Committee on Continuing Education.



SLSA - PART I STATISTICS

			<u>Mailing</u>	<u>Participation</u>
I	1.	Canvass letter to names from CDA computer	800	
	2.	Volunteered to participate (from 1) 336		
	3.	Actually participated (from 2)		177
II	1.	Canvass letter and Program to CDA Board, licensing bodies, deans, etc.	185	
	2.	Participated in Program (from 1)		58
	3.	Program to lay members	29	
		TOTALS 336	1,014	235

April 21, 1987



Resource 4
Appendix 2

SLSA BUDGET FOR PILOT

I	Item Development	\$10,000.
II	Translation	2,500.
III	Computer 500 at \$22.	11,000.
IV	Printing and Artwork	2,500.
V	Mailing	3,600.
VI	Production and Distribution	1,000.
VII	Miscellaneous (office supplies, etc)	400.
		\$31,000.

CDA	\$15,000.
NDEB	10,000.
CFDE	6,000.
\$31,000.	

REPORT ON INITIATIVES FOLLOWING UP ON CDA CONFERENCE ON PRELICENSURE

The CDA Conference on Prelicensure, held in Montreal, February 24-25, 1986, concluded with the following recommendations:

1. That the Council on Education and Accreditation and the Council on Hospital Services of the Canadian Dental Association, the National Dental Examining Board, and the Association of Canadian Faculties of Dentistry, in association with provincial licensing authorities, explore further the matter of prelicensure as part of an effort to review the entire dental education experience.
2. That governments, national and provincial authorities be encouraged to extend practice residency programs, and also support a review and evaluation of the delivery of dental care to federal and provincial institutions.
3. That the licensing bodies investigate interprovincial and/or national implications of prelicensure.

At the 1986 meeting of the Council on Education and Accreditation these recommendations were presented as part of the report on the conference. Council discussed what action should be taken and it was agreed that the Committee on Continuing Education should be asked to monitor and report on developments and initiatives following up on the Conference on Prelicensure or the concept of a requirement for a period of supervised clinical experience for graduates of dental education programs prior to licensure. Two developments in this context will be summarized briefly.

1. ACFD Task Force

The Association of Canadian Faculties of Dentistry responded to the recommendations of the Conference on Prelicensure by approving the establishment of a Task Force to review the educational implications of introducing a prelicensure period. Membership and terms of reference of the Task Force were established, but the Task Force has not met. It is understood that implementation of the Task Force has been placed on hold because of a subsequent development, a national meeting of the Deans of Faculties of Dentistry and recommendations resulting from this meeting.

2. National Meeting of Deans of Faculties of Dentistry

The Deans of Canadian Faculties of Dentistry met in Montreal on January 10, 1987 and again on February 21, 1987. The President of the ACFD attended both meetings. These national meetings served a variety of purposes including discussion of a presentation by R. K. House Associates on their recently completed study on manpower requirements in the dental health field.

Discussion also included consideration of the potential of the prelicensure concept to address a number of problems. It was noted that the knowledge base required for the practice of dentistry is increasing and that compromises in the treatment of the basic sciences are already apparent because of time constraints. Some licensing authorities have expressed concerns to increase the ethical foundation currently provided in dental education programs.

The Deans agreed that some action is required to provide leadership that can expedite dealing with the larger amount of material being fed into the dental education system. In this context, the prelicensure period was viewed not as a fifth year, but as a paid "residency". Accordingly questions of funding and government support are paramount.

It was also felt that a prelicensure period might provide more credence for the current licensure process.

Because of the complexity and interrelatedness of a whole range of issues including education, accreditation, prelicensure, licensure, manpower requirements and funding and the fundamental requirement that dental education meet the current and developing oral health needs of the population, the Deans suggested the formation of a Commission of government to conduct a broadly based review.

At the time of the preparation of this summary, the formal report of the Deans meeting was not available and more complete information may be provided to members of the Council on Education and Accreditation at the meeting in June.

Respectfully submitted,

Dr. George Beagrie, Chairman
Conference on Prelicensure

CDA/05/87

HEALTH CARE

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

Council Members: Dr. A. Toeman, Montreal, Quebec, Chairman
Dr. W. Allen, Charlottetown, P.E.I.
Dr. T.D. Fantin, Trail, B.C.
Dr. Keith I. Hamilton, Saskatoon, Saskatchewan
Mrs. Peggy Larder, CDHA, Halifax, N.S.
Mrs. Suzanne McIver, CDAA, Halifax, N.S.
Dr. G. McFarlane, Grand Falls, Newfoundland
Col. P.R. McQueen, CFDS, Ottawa, Ontario
Dr. R.B. Porter, Antigonish, N.S.
Dr. J.C. Rooney, Riverview, N.B.
Dr. D.G. Sage, Woodstock, Ontario
Dr. Kenneth R. Skinner, Winnipeg, Manitoba
Dr. J.C. Tsafaroff, DVA, Toronto, Ontario
Dr. Donald E. Upton, Calgary, Alberta
Dr. W. Bedford, Sr. Consultant Dentistry,
Health and Welfare, Ottawa, Ontario
Quebec representative - to be named

Executive Liaison: Dr. J.W. Niedermayer, Regina, Saskatchewan

1. Council Meeting

The full Council met November 13-14, 1986 in Ottawa and the Executive Sub-Committee met May 1, 1987.

Items Requiring Board Action

2. Use of Tobacco Products

APPENDIX A

At the direction of Executive Council, the Council on Health Care has developed a Policy on Tobacco Products and Health. (See Appendix A.)

RESOLVED:

87.106 THAT the appended Policy on Tobacco Products and Health be adopted.

ADOPTED

3. Bacterial Endocarditis - CDA Guidelines

APPENDIX B

Council reviewed proposed guidelines re: bacterial endocarditis and made the following recommendation:

RESOLVED:

- 87.107 THAT CDA endorse the new regimen for Prevention of Bacterial Endocarditis as defined by the American Heart Association, in conjunction with the American Dental Association Council on Dental Therapeutics (as printed in the CDA Journal, January 1986).

ADOPTED

4. Hepatitis B and Dentistry

APPENDIX C

Dentists and their staff members run a high risk of contracting Hepatitis B. In order to assist in minimizing this risk, the Council on Health Care has developed an information package for dentists. (See Appendix C.)

RESOLVED:

- 87.108 THAT the appended information on "Hepatitis B and the Dentist" be disseminated to all dentists in Canada through the Journal of the Canadian Dental Association.

ADOPTED

Council would like to thank Dr. John Hardie for his assistance in preparing the information on Hepatitis B.

Items for Information - Not Requiring Board Action5. Fluoridation Officer

As requested by Executive Council, the Council on Health Care has reactivated its Sub-Committee on Fluoridation, under the chairmanship of Dr. W. Allen. In addition, Dr. Ralph Burgess was requested to become the CDA Fluoridation Officer. Unfortunately, Dr. Burgess has declined this invitation and suggested that, due to the volume of the work involved, a full-time staff employee be appointed. The Council respectfully requests guidance as to how to proceed.

6. Provincial Radiation Protection Regulations

APPENDIX D

In order to assist members of the dental profession who may not be cognizant of the regulations pertaining to radiation protection which exist in their province, the Council on Health Care has compiled information from the Provinces and the N.W.T. concerning radiation protection. The appended chart provides an overview of what is required in each jurisdiction. (See Appendix D.)

Council feels this information will be helpful to dental students who are about to set up practice, immigrant dentists, and dentists who are planning to move from one province to another. It should also prove to be a handy reference guide to all dentists. It is thus planned that, after

editing, this chart will be published and updated annually in the Journal of the CDA. This project is in the preliminary stages and suggestions on format, content, etc. would be welcome and will be taken into consideration before publication.

Council would like to thank Dr. Gerry McFarlane for his work in developing the summary.

7. Questionnaire on Infection Control Procedures

The Council on Health Care has explored the potential for developing a questionnaire on the use of infection control procedures in dental practices. It was suggested that such a questionnaire could provide results which would assist CDA in its efforts to educate dentists on the importance of adopting effective infection control procedures and would assist in gathering information for related resources.

The Executive Sub-Committee presented a draft questionnaire to the Council for comment. Staff is now investigating the cost of developing such a questionnaire and processing the results in order to permit Council to formulate a recommendation on whether or not to proceed. Some members have expressed reservation about the utility of such an initiative and Council would appreciate any comments members of the Board might have.

Council would like to thank Dr. John Hardie for his assistance in preparing the draft questionnaire.

8. General Anaesthesia Guidelines

The Executive Sub-Committee has developed draft guidelines regarding "Ambulatory General Anaesthesia in Dental Offices" which will be discussed by the full Council in October.

9. I.V. Sedation

"Guidelines for the Utilization of Intravenous Sedation in Dentistry" are being developed and will be presented to the Board at its next meeting.

10. Control of Radiation in the Dental Office

The "CDA Guidelines for the Control of Radiation in the Dental Office" have been revised and presented to the Canadian Academy of Oral Radiology. Once CAOR approval has been received, the guidelines will be presented to the Board.

11. Geriatric Dentistry

As requested, the Council on Health Care is considering the role it could play in the promotion of Geriatric Dentistry and will report back in future.

12. I.D. Systems

At the direction of Executive Council, the Council on Health Care is considering the issue of use of identification systems and will present a report on its findings at the next Board meeting. The report will emphasize why i.d. systems are recommended and will list procedures currently available.

13. Confectionery Manufacturers' Association of Canada

The Council has received a request from the Confectionery Manufacturers' Association of Canada (CMAC) to support its claim that confectionery makes up only a small percentage of cariogenic substances. Council did not feel that this would be in the best interests of dentistry and has turned down the request. The CMAC plans to mount a substantial public awareness campaign, of which dentists should be aware. In fact, the Journal of the CDA was asked to become one of the advertisers, but, on the advice of members of Executive Council, the ad has been rejected.

14. Sports Dentistry

The Council continues to receive regular reports from Dr. A. Wood on his work in the field of Sports Dentistry. Dr. Wood's participation in Canadian Standards Association activities has greatly furthered Sports Dentistry in Canada.

15. Policy Statement on Sweeteners in Medication - Feedback

The Council was pleased to see that its Policy Statement on Sweeteners in Medication has been well-received by other interested associations. In support of the Policy, the Canadian Pharmaceutical Association has issued a label for use in pharmacies warning that the medication contains sugar. In addition, the Proprietary Association of Canada has also been working toward eliminating sugar in medications.

16. Standard Dental Referral Form

The Standard Dental Referral Form, approved at the 1986 Annual Board of Governors meeting, has been distributed to every dentist in Canada through the February issue of the Communiqué. Copies have also been sent to each of the Corporate Bodies for their files.

17. Review of Terms of Reference

Council reviewed the experimental structure of using an Executive Sub-Committee as a working committee and agreed that it had been a success. Although formal terms of reference were not deemed necessary, the Council decided to continue with the Executive Sub-Committee structure. Nominations were solicited and Drs. T.D. Fantin and D.G. Sage were elected for another year's term.

Respectfully submitted,

Andrew Toeman, D.D.S.
Chairman, Council on Health Care

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Health Care with appreciation.

CDA Policy on Tobacco Products and Health

Practising dentists see firsthand the initial signs of oral problems that arise when individuals use tobacco products, including smokeless tobacco. Dentists are concerned that tobacco products have been shown to contribute to oral diseases, including oral cancer.

The use of tobacco products is the leading cause of preventable death and disease in Canada, accounting for some 30,000 deaths annually. The Canadian Dental Association recognizes, with deep concern, the effects of the use of tobacco products, including smokeless tobacco, on both general and oral health. The following policy affirms the need to eliminate the use of all tobacco products in Canada and establish a norm of non-smoking as a social attitude for Canadians.

1. - The Canadian Dental Association applauds government's efforts to ban all advertising and promotion of tobacco products.
2. - CDA urges that regulations prohibiting the sale of all tobacco products to minors be strictly enforced.
3. - CDA encourages governments to develop educational programs aimed at smoking prevention among Canadians in general, but particularly in our school systems.
4. - CDA urges dentists to set an example to the general public by not using tobacco products.
5. - CDA encourages dentists to place no smoking signs in their reception areas and declare their offices smoke-free environments.
6. - CDA urges governments to encourage those engaged in the cultivation, production and sale of tobacco products to find alternative crops and to diversify into alternative activities.
7. - CDA urges the prohibition of exporting tobacco and tobacco products, especially to Third World countries.
8. - CDA urges that the health of non-smokers be protected by banning smoking in all public places, through provincial legislation and/or municipal bylaws, and specifically urges that smoking be banned in all workplaces, schools, health care facilities and public transport systems.

As evidence of CDA's commitment to the above policy, it has:

- (a) already declared a no smoking clean air policy for its work and meeting environments; and
- (b) adopted a policy of refusing to accept tobacco advertisements in any of its publications.

Because of the experience of the dental profession with the oral manifestations of problems associated with the use of tobacco products, it is our moral and professional responsibility to encourage, as an on-going priority, the eradication of the use of tobacco products.

Scientific

THE DENTAL MANAGEMENT OF THE CARDIAC PATIENT REQUIRING ANTIBIOTIC PROPHYLAXIS

C. Kilmartin, BDS, MSc, DDS, FRCD(C)*
Charles Munroe, BChD, FDSRCS, MD**
Toronto, Ontario

ABSTRACT

In this article, the concept of patients at higher and lower risk of developing Infective Endocarditis is discussed. Treatment planning modifications which may be necessary for these patients, are discussed and recommendations for specific situations are developed. These are primarily applicable to lower risk patients, treated in a general practice situation.

SOMMAIRE

Dans cet article, il est question des patients qui risquent peu ou fort d'avoir une endocardite infectieuse. Il est question également des modifications qu'il faudra peut-être apporter au plan de traitement et on offre des recommandations pour des situations précises. Celles-ci sont valables principalement pour les patients présentant des risques peu élevés et soignés dans un cabinet ordinaire.

INTRODUCTION

Once it is established that a patient needs antibiotic coverage, the dentist should know that several levels of risk for endocarditis have been identified. (Figs. 1, 2) The most recent guidelines from the American Heart Association⁴ identify two major categories of risk, with the standard regimen being used for the lower level. (Fig. 3) Worldwide, attempts have been made to identify

different levels of risk, for specific cardiac conditions, but no consensus has been achieved. Most authorities agree that prosthetic valve patients fall into the high risk category.^{1,2,4} The Australian Heart Association² describes this group as one who would "seem not only to experience a greater risk but in whom the consequences of infective endocarditis are potentially more serious".

The AHA⁴ favors the use of parenteral prophylactic antibiotics for those patients at particularly high risk of infective endocarditis. (Prosthetic valve patients and patients with a surgically constructed systemic-pulmonary shunt.) Some patients with a prosthetic heart valve in whom a high level of oral health is being maintained, may be offered oral antibiotic prophylaxis for routine dental procedures. Parenteral antibiotics are recommended however, for patients with prosthetic valves who require extensive dental procedures, especially extractions or oral or gingival surgical procedures. This may necessitate referring these patients to a hospital dental department where this is possible. Generally speaking, patients at highest risk of developing I.E. should have the simplest dental treatment plans, with heavy emphasis on preventive dentistry, oral hygiene and maintenance of a healthy mouth.

For all at risk patients antibiotic prophylaxis is recommended in those situations most likely to be associated with significant bacteraemia since infective endocarditis

cannot occur without a preceding bacteraemia. This is more likely to occur in patients with poor oral hygiene, abundant plaque, or active periodontal disease. It is also more likely to occur with certain dental procedures e.g. extractions, periodontal surgery, and deep scaling. It is most likely to occur when the latter procedures are carried out in the presence of inflammation. The Australian policy² lists dental procedures which may place patients at risk — this list has been modified to include other invasive procedures which would obviously result in bleeding — e.g. vital pulpal extirpation. (Fig. 4) Prophylactic coverage is now recommended in all situations where gingival bleeding is anticipated,⁴ (American policy) and for any dental procedure which causes bleeding² (Australian policy). However, it is recognized that dental procedures may be over-rated as a possible precipitating cause of I.E.^{2b} and that gingival bleeding, which is currently used as the essential indicator for prophylaxis, may not be the only situation requiring coverage.

Treatment Planning Modification in Cardiac Patients

Patients with rheumatic heart disease with no evidence of congestive cardiac failure and patients with asymptomatic congenital heart disease can receive any indicated dental treatment as long as appropriate antibiotics are used to prevent infective endocarditis.³

The prophylactic coverage given is that recommended by the AHA* (December '84) (Fig. 3) and the oral route is usually selected because of the lower incidence of serious allergic reactions, convenience, and better patient compliance. Penicillin is the current drug of choice, however, in cases of allergy it may be necessary to switch to an alternative antibiotic, e.g. erythromycin.

In general terms, patients at risk of developing infective endocarditis should have the highest level of oral health. Even in the absence of dental procedures, poor dental hygiene or dental disease such as periodontal or periapical infections may induce bacteraemia. Patients with ill fitting dentures that produce ulcers are also at risk.¹⁷

Common sense must prevail in drawing up a treatment plan for these patients. The

possible dental benefits must be weighed carefully against the very real medical hazards involved. Unless the patient has exceptionally good oral hygiene and the procedure has an excellent prognosis, it is wise to avoid complicated dental procedures. As indicated earlier, this is particularly true for patients at highest risk of I.E.

All patients should be advised of the other options open to them, e.g. extraction of the problem tooth with or without a subsequent prosthesis and of the possible problems following endodontics or surgery. In this way, the patient can participate in an informed decision.

Timing of Antibiotic Prophylaxis:

The regimen now recommended for oral administration involves a loading dose and

one post-operative dose. The current AHA policy underlines the fact that it is the initial high dose of antibiotic, shortly before the dental appointment, that is important. This large loading dose produces high serum levels of the antibiotic at the time of bacteraemia. This concept is critical to the basis for current prophylactic regimens.^{4,2,10} It replaces the older idea of "sterilizing" the mouth prior to treatment. The dentist should do as much as possible during each coverage period (e.g. quadrant dentistry), so that the required number of coverage periods can be reduced to a minimum. One hour is allowed to lapse between taking Penicillin V and starting dental treatment to allow for gastric absorption and the achievement of adequate serum levels. Dental work is performed only on the first day⁶ of the coverage period, preferably in the first 3-4 hours⁵ after the loading dose, because the bacteraemia then produced will be of penicillin-sensitive microorganisms. Dental work performed after this 3-4 hours, which could result in a bacteraemia, should be covered with an additional loading dose.⁵ Garrod and Waterworth⁷ gave a clear warning of the danger in administering penicillin for some days before surgery, as resistant strains can certainly appear in the mouth within 48 hours of its being started. The result of commencing penicillin administration too early is to eliminate the penicillin sensitive streptococci in the mouth, and allow the proliferation of more resistant strains.⁸ Any bacteraemia then produced, will contain a much higher percentage of resistant micro-organisms, and could result in an endocarditis which would be more difficult to treat. This is the rationale for advising that dental treatment should be performed on the first day only of the coverage period,¹⁹ preferably in the first 3-4 hours after the loading dose. As bacteraemias rarely persist for more than 15 minutes after the dental procedure which causes gingival bleeding, a single post-operative dose, six hours later, is now recommended for most routine situations. However, as the AHA recommendations warn,⁴ "It is not possible to make recommendations for all possible clinical situations. Practitioners must exercise their clinical judgement in determining the duration and choice of antibiotic when special circumstances apply." Where post-operative infection is anticipated, a longer post-operative course of antibiotics may be advisable.

The patient's physician sometimes advises the consulting dentist on the antibiotic regimen to be followed. When this advice is clearly incorrect (e.g. the use of an inappropriate antibiotic such as tetracycline, or inappropriate timing — such as

FIG. 1

Cardiac Conditions*

Endocarditis Prophylaxis Recommended:

- Prosthetic cardiac valves (including biosynthetic valves)
- Most congenital cardiac malformations
- Surgically constructed systemic-pulmonary shunts
- Rheumatic and other acquired valvular dysfunction
- Idiopathic hypertrophic subaortic stenosis (IHSS)
- Previous history of bacterial endocarditis
- Mitral valve prolapse with insufficiency**

Endocarditis Prophylaxis Not Recommended:

- Isolated secundum atrial septal defect
- Secundum atrial septal defect repaired without a patch six or more months earlier
- Patent ductus arteriosus ligated and divided six or more months earlier
- Post-operative coronary artery bypass graft (CABG) surgery

- * This table lists common conditions but is not meant to be all-inclusive.
- ** Definitive data to provide guidance in management of patients with mitral valve prolapse are particularly limited. It is clear that in general such patients are at low risk of development of endocarditis, but the risk-benefit ratio of prophylaxis in mitral valve prolapse is uncertain.

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FIG. 2

Patients at Risk*

Susceptible Patients (Group A)

Patients with a history of:

- a. Congenital heart disease including ventricular septal defect, tetralogy of Fallot, aortic stenosis, complex cyanotic heart disease, patent ductus arteriosus or systemic to pulmonary arterial shunts. (Does not include uncomplicated secundum atrial septal defect.)
- b. Rheumatic or other acquired valvular heart disease.
- c. Idiopathic hypertrophic subaortic stenosis.
- d. Patients with a permanent transvenous pacemaker.
- e. Patients with a history of prosthetic or vascular repair surgery.
- f. Patients with a history of luetic (syphilitic) heart disease, calcific aortic stenosis, calcified mitral annulus.
- g. Patients addicted to drugs administered intravenously.
- h. Patients with mitral valve prolapse syndrome or mitral insufficiency.

Highly Susceptible Patients (Group B)

Patients with the following histories have a high risk of contracting infective endocarditis subsequent to dental treatment and the consequences of the disease are likely to be serious:

- a. Patients with a history of infective endocarditis.
- b. Patients with a prosthetic heart valve.

- * Therapeutics Advisory Committee. Australian Dental Journal, February, 1980.

starting medication the day before the dental appointment) the dentist may choose to handle the situation by thanking the physician for his advice but informing him that he always uses the American Heart Association's Recommendations.⁴ It is extremely uncommon for a physician to deliberately give advice contrary to AHA official policy and should this happen, the dentist may choose to consult a cardiologist. The dentist should remember, however, that the final responsibility for his patient's welfare lies with him and that some physicians may not be as familiar with current AHA policy on antibiotic prophylaxis, as he is.

Where multiple dental appointments are necessary it is advisable that at least two weeks^{5,9}, be allowed to elapse between coverage periods. This is to prevent the development of penicillin resistant organisms by too frequent exposure to penicillin. It is preferable to extend this time interval where feasible, to allow the oral flora to return to normal.

Recommendations for Specific Dental Situations

Sadowsky and Kunzel²⁵ interviewed 322 dentists by phone to determine their knowledge of the AHA's recommendations on antibiotic prophylaxis, and their compliance with these recommendations. Dentists from urban and rural areas were sampled. They found that nearly a third of general dental practitioners would consider the use of antibiotic prophylaxis for all dental procedures, for patients at risk. This practice indicates a lack of understanding of the reasons why antibiotics are used on cardiac risk patients, and of the situations most likely to be associated with a bacteraemia. This same apparent clinical confusion was noted amongst the students at U of T and led to the following general guidelines. Obviously, however, each case still requires individual assessment. High risk cases are not usually treated by Toronto undergraduates so these recommendations are applicable, unless otherwise stated, to patients at lower risk of I.E. Although these guidelines were initially prepared for the guidance of students, it is felt that they reflect basic principles and can be usefully applied to general practice.

Crowns and Bridges¹¹

Crowns and bridges can be made for these patients with proper planning and preparation. During one coverage period the preparations can be made, impressions taken and temporaries made. It is especially important that well constructed temporaries be made so that the optimal gingival health, which should have been established in the early visits, can be maintained. Margins should be supra gingival where possible.

FIG. 3

Summary of Recommended Antibiotic Regimens for Dental/Respiratory Tract Procedures⁴

Standard Regimen

For dental procedures that cause gingival bleeding, and oral/respiratory tract surgery.

Special Regimens

Parenteral regimen for use when maximal protection desired; e.g., for patients with prosthetic valves

Oral regimen for penicillin-allergic patients

Parenteral regimen for penicillin-allergic patients

Penicillin V 2.0 g orally one hour before, then 1.0 g six hours later. For patients unable to take oral medications, 2 million units of aqueous penicillin G IV or IM 30-60 minutes before a procedure and 1 million units six hours later may be substituted.

Ampicillin 1.0-2.0 g IM or IV plus gentamicin 1.5 mg/kg IM or IV, one-half hour before procedure, followed by 1.0 g oral penicillin V six hours later. Alternatively, the parenteral regimen may be repeated once eight hours later.

Erythromycin 1.0 g orally one hour before, then 500 mg six hours later

Vancomycin 1.0 g IV slowly over one hour, starting one hour before. No repeat dose is necessary.

Note: Pediatric doses: Ampicillin 50 mg/kg per dose; erythromycin 20 mg/kg for first dose, then 10 mg/kg; gentamicin 2.0 mg/kg per dose; penicillin V full adult dose if greater than 60 lb (27 kg), one-half adult dose if less than 60 lb (27 kg); aqueous penicillin G 50,000 units/kg (25,000 units/kg for follow-up); vancomycin 20 mg/kg per dose. The intervals between doses are the same as for adults. Total doses should not exceed adult doses.

Circulation, Vol. 70, No. 6, Dec. 1984, 1123A-1127A.

Reproduced with Permission. Prevention of Bacterial Endocarditis. American Heart Association

FIG. 4

Procedures Requiring Antibiotic Prophylaxis*

A 1980 report from an Australian Therapeutics Advisory Committee² has listed dental procedures which may place susceptible patients at risk as follows:

a. Any dental procedure which causes bleeding. The greatest risk will occur after the following procedures:

1) extraction of teeth;

2) oral surgery;

3) periodontal surgery including scaling and subgingival curettage;

4) subgingival scaling and root planing;

5) some subgingival cavity preparations where bleeding is likely to occur.

The risk will be greater for all these procedures in the presence of periodontal disease.

b. Drainage of dental abscess by incision, tooth removal or through the pulp canal.

c. Endodontic procedures which may cause a bacteraemia are:

1) treatment of infected pulps;

2) procedures which extend beyond the apex of the tooth.

d. Manipulation of mobile teeth, as during impression taking or during re-positioning of teeth following trauma.

e. Insertion of immediate dentures.

f. Re-implantation of avulsed teeth.

Antibiotic coverage is required for any dental procedure which causes bleeding; this includes vital pulpal extirpation, periodontal probing; periapical curettage, etc.

*Therapeutics Advisory Committee. Australian Dental Journal. February, 1980.

FIG. 5

Procedures which DO NOT Require Antibiotic Coverage²²

1. Alginate impressions of periodontally healthy, non-mobile teeth and edentulous patients;

2. Endodontic treatment, on non-vital teeth, confined to the root canal;

3. Adjustment of orthodontic appliances;

4. Restorative procedures on the occlusal surfaces of teeth (where rubber damp clamp NOT used);

5. Injection of L.A. when tissue surface is prepared carefully with an antiseptic solution.

Brooks, S.L. and Millard, H.D. "The Damaged Heart, Part 1". Dental Clinics of North America, Vol. 27, No. 2, April 1983.

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CARDIAC PATIENT: KILMARTIN ET AL

79

Prosthodontics¹¹

Antibiotic coverage is not considered necessary for any phase of full denture construction. Special care must be taken in the immediate post-insertion period to prevent the development of sore spots.

This may be achieved by:

- a) counselling patients to return for immediate adjustments, should any sore areas develop;
- b) seeing the patient every second day for evaluation until dentures are being worn comfortably;
- c) the use of a soft-diet for the first two weeks following insertion of the dentures;
- d) careful attention to all phases of denture construction to achieve optimal fit.

Prior to partial denture construction, the sanative phase of periodontal treatment must be completed and the patient's oral hygiene should be satisfactory. Antibiotic coverage is then not required for any phase of partial denture construction, assuming the remaining teeth are periodontally healthy.

When teeth are to be extracted and immediate dentures inserted, it is often because of severe periodontitis. Antibiotic coverage is therefore required for impression procedures and, of course, for the surgical phase. Meticulous care must be given in the post-insertion period to prevent the development of sore spots, as discussed above.

Oral Surgery¹²

The following general guidelines may be useful and serve as a basis for discussion with the patient's physician:

- a) all patients with damaged heart valves require antibiotic prophylaxis prior to surgery;
- b) a new patient presenting for an extraction with a history of rheumatic fever and no known cardiac damage is commonly routinely covered. These are usually emergency procedures so that often there is not sufficient time to investigate the patient's cardiac status;
- c) following an oral surgical procedure, should an infection develop following cessation of prophylactic penicillin therapy, and where no additional surgery is contemplated, the infection is treated by re-instituting penicillin as it is felt that penicillin is more effective against oral infections than erythromycin. The alternative antibiotic in this situation is clindamycin;
- d) patients presenting with pericoronitis who are going to require subsequent extraction of the wisdom teeth have their pericoronal infection treated routinely, i.e. with penicillin, mouth washes, etc. and two — three weeks later, are given appropriate

further penicillin coverage for extraction of the teeth;

- e) in addition to the antibiotic coverage, in cases involving a surgical procedure, the site should be cleansed and an antiseptic such as iodine 1 per cent should be applied to the area.

Endodontics²⁹

As in all other phases of dentistry, it is prudent to minimize the number of appointments requiring antibiotic prophylaxis and to space them appropriately. To this end, it is suggested that whenever possible most teeth be finished in two appointments, spaced apart by at least two weeks. The first appointment could include pulpectomy and canal preparation, the second appointment could therefore be used to obturate the tooth.

The question then of whether or not to root-treat a given tooth is a very individual one requiring evaluation of both the patient's medical and dental conditions.

Patients at high risk of developing I.E. are special cases and are usually not considered suitable candidates for endodontics because of the potential, however remote, for residual infection or flare-ups. There is however, considerable debate over which is best, endodontic treatment or an extraction. In the latter instance a procedure with a high possibility of bacteraemia occurs but the patient is not usually left with a potential situation for chronic infection or acute flare-ups, as may occur, however rarely, in endodontics. Although periapical disease in a quiescent form cannot be assumed to be a predisposing cause of bacteraemia,¹³ it may nonetheless result in an apical abscess, a situation which most likely could. Harty¹⁴ indicates that *high risk patients* (which he defines as patients with a previous history of I.E., or those who have had cardiac surgery with the implantation of a prosthesis) should be considered a contraindication to endodontic therapy. Seltzer,¹⁵ however, says that in patients with rheumatic heart disease, (lower risk patients) endodontic therapy is the therapy of choice because of the lower probability of bacteraemias. McGowan¹⁶ advises that it is safer to reduce the numbers of episodes of exposure to bacteraemia by one visit root filling combined with immediate apical curettage or apicectomy if required, so that the most effective AB prophylaxis can be applied once and for all. The AHA says that "patients at risk for bacterial endocarditis should maintain the best possible oral health to reduce potential sources of bacterial seeding because poor dental hygiene or periodontal or *periapical* infections may induce bacteraemia even in the absence of dental procedures". Because of these variables

and lack of firm data, each case requires individual consideration. However in patients at high risk of developing I.E. the authors would, as a general rule, recommend extraction of all questionable teeth under appropriate antibiotic coverage. For patients at lesser risk, the likelihood of endodontic success must be carefully assessed and endodontic therapy may be carried out on teeth where the prognosis is deemed good.

Periodontics³⁰

A healthy periodontium is probably a major factor in reducing the incidence of bacteraemias, iatrogenic or otherwise, in the cardiac risk patient. Therefore this aspect of the treatment plan has particular importance for these patients. Once a healthy periodontal condition has been achieved, maintenance, through careful oral hygiene procedures and regular recall visits must be stressed. In high risk cases, it is not advisable to leave in situ, teeth whose long term prognosis is doubtful, and which may be potential sources of bacteraemias. Clinical judgement is clearly all-important. In higher risk patients there is less leeway for maintaining teeth with a diseased periodontium. Ideally, all teeth in these patients would be non-mobile and free from inflammation. Bifurcation accessibility is a particular concern in high risk patients and could be sufficient grounds for considering extraction.

Adjunctive Measures to Antibiotic Prophylaxis

Additional precautions can be taken to minimize the extent of bacteraemia from a dental procedure. These measures are not meant to be used instead of prophylactic antibiotic coverage, but rather as adjunctive measures and may include:

1. Sulcal irrigation and mouth wash with 1 per cent Povidine-Iodine Solution^{18,19}
2. Instillation of chlorhexidine 0.2 per cent² or 1 per cent¹⁸

It appears the most effective method of using topical antiseptics to reduce bacteraemia is by irrigation of the gingival sulcus.¹⁹ In the clinical study performed by Scopp¹⁹ the gingival sulcus of each tooth to be extracted and the surrounding gingival mucosa of the quadrant were irrigated for approximately 1 minute with 10-20 ml of the assigned solution with use of a standard luer-lok syringe and blunt angulated needle. Prior to this, the patient rinsed the mouth for 30 seconds with 10-20 ml of the assigned mouth wash, waited two minutes and repeated the rinse.

In Conclusion:

1. Take an adequate medical history. Ask about

- 1) rheumatic fever
- 2) heart murmurs
- 3) other serious illness
- 4) hospitalization
2. Clarify any vague replies through consultation with patient's physician.
3. Update this history regularly.
4. Use AHA guidelines for antibiotic prophylaxis.⁴ (Fig. 3)
5. Allow at least two weeks to elapse between appointments requiring antibiotic coverage. Extend this time when possible.
6. If the patient has taken penicillin in the two-week period prior to his dental appointment, use I.M. coverage where possible. Alternatively, oral erythromycin can be used.
7. Stress the importance of attaining and maintaining good oral health.
8. Have the patient report to you or his physician any unexplained change in his health following dental procedures. Most cases of I.E. develop two weeks after the dental procedure, but some have been thought to take up to three months to develop.
9. Use appropriate adjunctive procedures to reduce degree of bacteraemia, when indicated.

Specific Examples

1. Patient has history of rheumatic fever, enjoys excellent health. Has no murmur (confirmed by physician). *No antibiotic required*^{20,21,22,23}
2. Any patient with a history of rheumatic fever who has a heart murmur, EVEN IF in excellent health. *Requires antibiotic prophylaxis.*
3. Any patient with a heart murmur which represents DAMAGE to the endocardium (no matter the causative disease). *Requires antibiotic prophylaxis.*
4. Dosage and method of antibiotic prophylaxis. *Use AHA Guidelines. (1984, Fig. 3)*
5. Patient requiring antibiotic prophylaxis is allergic to penicillin and erythromycin. *In certain cases, oral clindamycin* can be used²⁴ but this should be discussed with the patient's cardiologist. The AHA⁴ also mentions oral cephalosporins (1.0 gm 1 hour before the procedure plus 500 mg 6 hours later) but says that specific data are lacking to allow specific recommendations of this regimen. Tetracyclines cannot be recommended for this purpose.*
- *Dosage of clindamycin: A loading dose of 450 mg (3 tabs) one hour before the procedure and 300 mg 6 hours later.
6. Period between dental appointments in a patient requiring antibiotic prophylaxis.

Two week minimum, preferably longer.

N.B. If there are aspects of the treatment plan that can be carried out without antibiotic prophylaxis, these can be done within the two week period, e.g. intracoronal restorations that can be done without rubber dam.

7. In any patient with a heart murmur, you must ascertain if this is "functional/benign" or whether it represents a structural abnormality secondary to disease.

All heart murmurs must be checked out by consultation with the patient's physician (by telephone or letter), unless the patient has a clear understanding of the significance of heart murmurs to dentistry and has been assured by his physician that his is of NO consequence. Many patients believe they have a "mild" heart murmur, which on consultation with their physician, turns out to be a mitral valve prolapse, a condition which does require coverage.

However:

8. If a patient with a heart murmur is ambiguous about its nature or if doubt still exists. *Contact physician re antibiotic prophylaxis.*
9. A patient with a history of rheumatic fever is on continuous low-dose penicillin therapy as prophylaxis against streptococcal tonsillitis and requires antibiotic prophylaxis. *Oral erythromycin or one of the parenteral regimens.⁴*
10. In general, a patient requiring antibiotic prophylaxis for a heart condition should receive specific dental treatment only if the long term prognosis for that procedure is excellent.
Examples:
(a) Poor hygiene and a badly neglected dentition with advanced periodontal disease. This patient may be better off with extractions of those teeth whose future prognosis remains in doubt.
(b) Necrotic, grossly infected teeth especially molars whose endodontic future is in doubt should be extracted.

Conclusion

The information in this article is intended to provide the reader with *GUIDELINES* only concerning the management of patients with cardiovascular disease. *ALL* cases must be assessed individually, if necessary in conjunction with the patient's physician, to establish an optimum treatment plan for that patient. In addition, it is essential to warn patients at risk from I.E. (even if prophylactic AB coverage has been given) to report back if even a minor febrile illness develops after dental treatment.

It is unfortunate, but nonetheless obvious that this entire issue has been influenced by medicolegal considerations. It is also necessary to say that there are authorities²⁷ who feel that the benefits of prophylaxis — particularly for low risk patients may be outweighed by the possible disadvantages — e.g. allergy, adverse reactions. In the final analysis however, it is prudent to follow the recommendations of this continent's most authoritative body on this subject, the American Heart Association. In conclusion, perhaps the most important yet least emphasized factor in helping to prevent I.E. of dental origin, is to stress to the patient the importance of good oral health and oral hygiene procedures. As Oakley²⁶ and Somerville have said, "It is a sobering thought that a rise in the standard of oral hygiene throughout the country would probably help more than any other measure to reduce the incidence of streptococcal infective endocarditis."

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HEPATITIS B AND DENTISTRY - AN UPDATE

Introduction

This brief report stresses three aspects of Hepatitis B infection:

1. - prevention of the disease.
2. - interpretation of blood tests for Hepatitis B.
3. - actions to be taken if a member of the dental team suffers a "needle-stick" injury from a suspected or known Hepatitis B infected patient.

Prevention

A 1984 report demonstrated that 12% of Canadian dentists had been exposed to the Hepatitis B virus (HBV). A 1985 survey revealed an exposure rate of 13%, with only 25% of those surveyed having received vaccine. In addition, few dentists reported practising the appropriate and recommended infection control procedures. Dentists should be aware that, while Hepatitis B is an occupational health hazard, its transmission via the dental environment is reduced if the following approach is adopted.

Prevention = - H - High Risk Groups
 - B - Barrier Techniques
 - V - Vaccine

High Risk Groups

The recognized high risk groups are:

homosexually active men;
prostitutes;
patients with multiple episodes of sexually transmitted diseases;
users of illicit injectable drugs;
patients receiving dialysis, blood transfusions or blood products;
residents and staff of mental institutes;
health care workers and students, especially those exposed to blood and body fluids (this includes dental staff);
sexual and household contacts of all the above.

NOTE - Unlike AIDS, Hepatitis B is not only sexually transmitted, but may be transferred via person-to-person or person-to-object-to-person contact.

This implies that the occupation of the patient, spouse or parents is essential information. A positive history of Hepatitis B on a medical questionnaire may be significant, but many patients are unable to differentiate the various types of hepatitis. It is essential that dentists be able to interpret the different serological markers associated with Hepatitis B (see Fig. 1).

Fig. 1

USUAL MARKERS					
HBS AG	-	Hepatitis B Surface Antigen			
HBE AG	-	Hepatitis B "E" Antigen			
ANTI HBC	-	Hepatitis B Core Antibody			
ANTI HBE	-	Hepatitis B "E" Antibody			
ANTI HBS	-	Hepatitis B Surface Antibody			
+	-	Detected			
-	-	Not Detected			

HEPATITIS B TEST RESULTS					
	HBS AG	HBE AG	ANTI HBC	ANTI HBE	ANTI HBS
Early, Acute Disease	+	-	-	-	-
Acute, Infectious Stage	+	+	-	-	-
Acute (Infectious) Carrier	+	+	+	-	-
Convalescence or Chronic Stage	+	+	+	+	-
Acute or Carrier Stage	+	-	+	+	-
Convalescence	-	-	+	+	-
Recovery or Immunity	-	-	+	+or-	+or-

Barriers

1. For the Dental Team

- Wearing of fresh gloves for each patient.
- Washing ungloved hands between patients.
- Wearing protective eyeglasses and masks when treatment will produce spattering of blood or body fluids.
- Wearing protective gowns when blood spatter is likely. Such gowns should be changed at least daily, washed with bleach, and never worn outside the working environment.
- Use of rubber dams whenever possible.
- Use of high speed suction to eliminate aerosols.

2. For the Patient

- A dental team who are recipients of the Hepatitis B vaccine.
- An environment in which appropriate infection control procedures are practised.

3. For the Dental Environment

- Appropriate care of sharp instruments and needles.
- Effective sterilization or high level disinfection of all instruments in contact with the oral environment.
- Effective decontamination of environmental surfaces.
- Recommended use and care of ultrasonic scalers, handpieces and dental units.

Recommended Infection - Control Practices for Dentistry

Preamble - The following article is reprinted from the Morbidity and Mortality Weekly Report, April 18, 1986, Volume 35 Number 15. It represents the authoritative opinion of the consultants at the Centre for Disease Control, Atlanta, Georgia. It is being published in the Journal to inform readers of current infection-control practices.

NOTE - A reprint of the "Recommended Infection-Control Practices for Dentistry" is included with this report. In addition to being familiar with these practices dentists should be aware of the procedures to adopt should a "needle stick" or similar percutaneous injury occur to a staff member. (see Fig. II)

Fig. II

Recommendations for Hepatitis B
Prophylaxis Following Percutaneous Exposure

Exposed Person (Dental Staff)

Source	Unvaccinated	Vaccinated
HBsAG positive	1. HBIG x 1 immediately* 2. Initiate HB vaccine** series. 2.	1. Test exposed person for anti-HBs. If inadequate antibody*** HBGIG(x1) immediately plus HB vaccine booster dose.
Known source		
High-risk HBsAG-positive	1. Initiate HB vaccine series 2. Test source for HBsAg, If positive, HBIG x 1.	1. Test source for HBsAG only if exposed is vaccine non-responder; if source is HBsAg positive, give HBIG x 1 immediately plus HB vaccine booster dose.
Low-risk HBsAg-positive	Initiate HB vaccine series.	Nothing required.
Unknown source	Initiate HB vaccine series.	Nothing required.

* HBIG dose 0.06 ml/kg IM (Hepatitis B immunoglobine).

** HB vaccine dose 20 ug IM for adults; 10 ug IM for infants or children under 10 years of age. First dose within one week; second and third doses, one and six months later.

*** Less than 10 SRU by RIA, negative by EIA.

Table adapted from MMWR 34:331, 1985.

Vaccine

Hepatitis B vaccine (Heptavax) has been available since 1982. It has been proven to be both safe and effective. It does not transmit Hepatitis B nor AIDS, and produces a positive immunological reaction in 90-95% of healthy individuals. Its effectiveness may decrease with increasing age, with one study demonstrating a significant increase in vaccine failure in recipients older than 40 years of age. This indicates a definite need for a postvaccination test of antibody status to ensure adequate protection, and should be performed 2-3 months after the last injection.

It must be stressed that while the vaccine will protect the recipient from infection with HBV, the recipient may still transmit the disease via contaminated hands, clothing or instruments. The vaccine will not convert a chronic carrier into a non-carrier. It is anticipated that the vaccine will be effective for at least 3-5 years. Notifications of the requirements for booster doses should be available in 1987.

Conclusions

There is no doubt that Hepatitis B is a serious health hazard to all members of the dental health team. While each dentist has the right to decide the degree to which he or she may wish to adopt these preventive measures, it does appear reasonable to assume that dentists have a responsibility to minimize the risk of transmission to staff and patients.

In Canada there are no legal precedents regarding the onus of responsibility where disease is transmitted in a dental environment via inadequate infection control practices. The chief Coroner of Ontario has recently recommended that there be a heightened awareness of the risks of HBV transmission between patients and members of the health professions, and that the safety and availability of vaccination be emphasized.

Council on Health Care
May 1987

MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

Recommended Infection-Control Practices for Dentistry

Dental personnel may be exposed to a wide variety of microorganisms in the blood and saliva of patients they treat in the dental operator. These include *Mycobacterium tuberculosis*, hepatitis B virus, staphylococci, streptococci, cytomegalovirus, herpes simplex virus types I and II, human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), and a number of viruses that infect the upper respiratory tract. Infections may be transmitted in dental practice by blood or saliva through direct contact, droplets, or aerosols. Although not documented, indirect contact transmission of infection by contaminated instruments is possible. Patients and dental health-care workers (DHCWs) have the potential of transmitting infections to each other (1).

A common set of infection-control strategies should be effective for preventing hepatitis B, acquired immunodeficiency syndrome, and other infectious diseases caused by bloodborne viruses (2-4). The ability of hepatitis B virus to survive in the environment (5) and the high titers of virus in blood (6) make this virus a good model for infection-control practices to prevent transmission of a large number of other infectious agents by blood or saliva. Because all infected patients cannot be identified by history, physical examination, or readily available laboratory tests (3), the following recommendations should be used routinely in the care of all patients in dental practices.

MEDICAL HISTORY

Always obtain a thorough medical history. Include specific questions about medications, current illnesses, hepatitis, recurrent illnesses, unintentional weight loss, lymphadenopathy, oral soft tissue lesions, or other infections. Medical consultation may be indicated when a history of active infection or systemic disease is elicited.

USE OF PROTECTIVE ATTIRE AND BARRIER TECHNIQUES

1. For protection of personnel and patients, gloves must always be worn when touching blood, saliva, or mucous membranes (7-10). Gloves must be worn by DHCWs when touching blood-soiled items, body fluids, or secretions, as well as surfaces contaminated with them. Gloves must be worn when examining all oral lesions. All work must be completed on one patient, where possible, and the hands must be washed and regloved before performing procedures on another patient. Repeated use of a single pair of gloves is not recommended, since such use is likely to produce defects in the glove material, which will diminish its value as an effective barrier.

2. Surgical masks and protective eyewear or chin-length plastic face shields must be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry (11,12).

Infection Control — Continued

3. Reusable or disposable gowns, laboratory coats, or uniforms must be worn when clothing is likely to be soiled with blood or other body fluids. If reusable gowns are worn, they may be washed, using a normal laundry cycle. Gowns should be changed at least daily or when visibly soiled with blood (13).

4. Impervious-backed paper, aluminum foil, or clear plastic wrap may be used to cover surfaces (e.g., light handles or x-ray unit heads) that may be contaminated by blood or saliva and that are difficult or impossible to disinfect. The coverings should be removed (while DHCWs are gloved), discarded, and then replaced (after ungloving) with clean material between patients.

5. All procedures and manipulations of potentially infective materials should be performed carefully to minimize the formation of droplets, spatters, and aerosols, where possible. Use of rubber dams, where appropriate, high-speed evacuation, and proper patient positioning should facilitate this process.

HANDWASHING AND CARE OF HANDS

Hands must always be washed between patient treatment contacts (following removal of gloves), after touching inanimate objects likely to be contaminated by blood or saliva from other patients, and before leaving the operatory. The rationale for handwashing after gloves have been worn is that gloves become perforated, knowingly or unknowingly, during use and allow bacteria to enter beneath the glove material and multiply rapidly. For many routine dental procedures, such as examinations and nonsurgical techniques, handwashing with plain soap appears to be adequate, since soap and water will remove transient microorganisms acquired directly or indirectly from patient contact (13). For surgical procedures, an antimicrobial surgical handscrub should be used (14). Extraordinary care must be used to avoid hand injuries during procedures. However, when gloves are torn, cut, or punctured, they must be removed immediately, hands thoroughly washed, and regloving accomplished before completion of the dental procedure. DHCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling dental patient-care equipment until the condition resolves (15).

USE AND CARE OF SHARP INSTRUMENTS AND NEEDLES

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries.

2. Disposable syringes and needles, scalpel blades, and other sharp items must be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, disposable needles should not be recapped; purposefully bent or broken; removed from disposable syringes; or otherwise manipulated by hand after use.

3. Recapping of a needle increases the risk of unintentional needlestick injury. There is no evidence to suggest that reusable aspirating-type syringes used in dentistry should be handled differently from other syringes. Needles of these devices should not be recapped, bent, or broken before disposal.

4. Because certain dental procedures on an individual patient may require multiple injections of anesthetic or other medications from a single syringe, it would be more prudent to place the unsheathed needle into a "sterile field" between injections rather than to recap the needle between injections. A new (sterile) syringe and a fresh solution should be used for each patient.

*Infection Control – Continued***INDICATIONS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION OF INSTRUMENTS**

Surgical and other instruments that normally penetrate soft tissue and/or bone (e.g., forceps, scalpels, bone chisels, scalars, and surgical burs) should be sterilized after each use. Instruments that are not intended to penetrate oral soft tissues or bone (e.g., amalgam condensers, plastic instruments, and burs) but that may come into contact with oral tissues should also be sterilized after each use, if possible; however, if sterilization is not feasible, the latter instruments should receive high-level disinfection (3, 13, 16).

METHODS FOR HIGH-LEVEL DISINFECTION OR STERILIZATION

Before high-level disinfection or sterilization, instruments should be cleaned to remove debris. Cleaning may be accomplished by a thorough scrubbing with soap and water or a detergent, or by using a mechanical device (e.g., an ultrasonic cleaner). Persons involved in cleaning and decontaminating instruments should wear heavy-duty rubber gloves to prevent hand injuries. Metal and heat-stable dental instruments should be routinely sterilized between use by steam under pressure (autoclaving), dry heat, or chemical vapor. The adequacy of sterilization cycles should be verified by the periodic use of spore-testing devices (e.g., weekly for most dental practices) (13). Heat- and steam-sensitive chemical indicators may be used on the outside of each pack to assure it has been exposed to a sterilizing cycle. Heat-sensitive instruments may require up to 10 hours' exposure in a liquid chemical agent registered by the U.S. Environmental Protection Agency (EPA) as a disinfectant/sterilant; this should be followed by rinsing with sterile water. High-level disinfection may be accomplished by immersion in either boiling water for at least 10 minutes or an EPA-registered disinfectant/sterilant chemical for the exposure time recommended by the chemical's manufacturer.

DECONTAMINATION OF ENVIRONMENTAL SURFACES

At the completion of work activities, countertops and surfaces that may have become contaminated with blood or saliva should be wiped with absorbent toweling to remove extraneous organic material, then disinfected with a suitable chemical germicide. A solution of sodium hypochlorite (household bleach) prepared fresh daily is an inexpensive and very effective germicide. Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected. Caution should be exercised, since sodium hypochlorite is corrosive to metals, especially aluminum.

DECONTAMINATION OF LABORATORY SUPPLIES AND MATERIALS

Blood and saliva should be thoroughly and carefully cleaned from laboratory supplies and materials that have been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Materials, impressions, and intra-oral appliances should be cleaned and disinfected before being handled, adjusted, or sent to a dental laboratory (17). These items should also be cleaned and disinfected when returned from the dental laboratory and before placement in the patient's mouth. *Because of the ever-increasing variety of dental materials used intra-orally, DHCWs are advised to consult with manufacturers as to the stability of specific materials relative to disinfection procedures.* A chemical germicide that is registered with the EPA as a "hospital disinfectant" and that has a label claim for mycobactericidal (e.g., tuberculocidal) activity is preferred, because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens (15). Communication between a dental office and a dental laboratory with regard to handling and decontamination of supplies and materials is of the utmost importance.

*Infection Control — Continued***USE AND CARE OF ULTRASONIC SCALERS, HANDPIECES, AND DENTAL UNITS**

1. Routine sterilization of handpieces between patients is desirable; however, not all handpieces can be sterilized. The present physical configurations of most handpieces do not readily lend them to high-level disinfection of both external and internal surfaces (see 2 below); therefore, when using handpieces that cannot be sterilized, the following cleaning and disinfection procedures should be completed between each patient: After use, the handpiece should be flushed (see 2 below), then thoroughly scrubbed with a detergent and water to remove adherent material. It should then be thoroughly wiped with absorbent material saturated with a chemical germicide that is registered with the EPA as a "hospital disinfectant" and is mycobactericidal at use-dilution (15). The disinfecting solution should remain in contact with the handpiece for a time specified by the disinfectant's manufacturer. Ultrasonic scalers and air/water syringes should be treated in a similar manner between patients. Following disinfection, any chemical residue should be removed by rinsing with sterile water.

2. Because water retraction valves within the dental units may aspirate infective materials back into the handpiece and water line, check valves should be installed to reduce the risk of transfer of infective material (18). While the magnitude of this risk is not known, it is prudent for water-cooled handpieces to be run and to discharge water into a sink or container for 20-30 seconds after completing care on each patient. This is intended to physically flush out patient material that may have been aspirated into the handpiece or water line. Additionally, there is some evidence that overnight bacterial accumulation can be significantly reduced by allowing water-cooled handpieces to run and to discharge water into a sink or container for several minutes at the beginning of the clinic day (19). Sterile saline or sterile water should be used as a coolant/irrigator when performing surgical procedures involving the cutting of soft tissue or bone.

HANDLING OF BIOPSY SPECIMENS

In general, each specimen should be put in a sturdy container with a secure lid to prevent leaking during transport. Care should be taken when collecting specimens to avoid contamination of the outside of the container. If the outside of the container is visibly contaminated, it should be cleaned and disinfected, or placed in an impervious bag (20).

DISPOSAL OF WASTE MATERIALS

All sharp items (especially needles), tissues, or blood should be considered potentially infective and should be handled and disposed of with special precautions. Disposable needles, scalpels, or other sharp items should be placed intact into puncture-resistant containers before disposal. Blood, suctioned fluids, or other liquid waste may be carefully poured into a drain connected to a sanitary sewer system. Other solid waste contaminated with blood or other body fluids should be placed in sealed, sturdy impervious bags to prevent leakage of the contained items. Such contained solid wastes can then be disposed of according to requirements established by local or state environmental regulatory agencies and published recommendations (13,20).

Developed by Dental Disease Prevention Activity, Center for Prevention Svcs, Hospital Infections Program, Center for Infectious Diseases, CDC.

Editorial Note: All DHCWs must be made aware of sources and methods of transmission of infectious diseases. The above recommendations for infection control in dental practices incorporate procedures that should be effective in preventing the transmission of infectious agents from dental patients to DHCWs and vice versa. Assessment of quantifiable risks to dental personnel and patients for specific diseases requires further research. There is no current documentation of patient-to-patient blood- or saliva-borne disease transmission from

Infection Control — Continued

procedures performed in dental practice. While few in number, reported outbreaks of dentist-to-patient transmission of hepatitis B have resulted in serious and even fatal consequences (9). Herpes simplex virus has been transmitted to over 20 patients from the fingers of a DHCW (10). Serologic markers for hepatitis B in dentists have increased dramatically in the United States over the past several years, which suggests current infection-control practices have been insufficient to prevent the transmission of this infectious agent in the dental operator. While vaccination for hepatitis B is strongly recommended for dental personnel (21), vaccination alone is not cause for relaxation of strict adherence to accepted methods of asepsis, disinfection, and sterilization.

Various infection-control guidelines exist for hospitals and other clinical settings. Dental facilities located in hospitals and other institutional settings have generally utilized existing guidelines for institutional practice. These recommendations are offered as guidance to DHCWs in noninstitutional settings for enhancing infection-control practices in dentistry; they may be useful in institutional settings also.

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Infection Control – Continued

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TABLE I. Summary—cases specified notifiable diseases, United States

Disease	15th Week Ending			Cumulative, 15th Week Ending		
	Apr. 12, 1986	Apr. 13, 1985	Median 1981-1985	Apr. 12, 1986	Apr. 13, 1985	Median 1981-1985
Acquired Immunodeficiency Syndrome (AIDS)	380	199	N	3,580	1,878	N
Aseptic meningitis	82	71	58	1,207	1,039	1,144
Encephalitis: Primary (arthropod-borne & unspec.)	14	21	19	235	271	258
Post-infectious	2	3	1	25	38	25
Gonorrhea: Civilian	15,880	15,194	15,194	224,979	223,900	256,543
Military	221	276	355	4,457	5,335	7,059
Hepatitis: Type A	405	407	418	8,437	8,114	8,575
Type B	498	536	434	7,042	7,139	6,532
Non A, Non B	54	88	N	932	1,195	N
Unspecified	95	123	127	1,429	1,482	2,093
Legionellosis	7	8	N	157	173	N
Leprosy	7	6	8	78	114	58
Measles	12	11	18	201	192	198
Measles: Total*	167	104	58	1,607	721	721
Indigenous	165	96	N	1,565	597	N
Imported	2	8	N	42	124	N
Meningococcal infections: Total	66	48	67	959	894	1,041
Civilian	66	48	67	957	893	1,040
Military	-	-	-	2	1	4
Mumps	137	62	101	970	1,194	1,254
Pertussis	23	35	35	545	436	436
Rubella (German measles)	11	11	34	145	115	344
Syphilis (Primary & Secondary): Civilian	420	433	540	6,821	7,051	8,771
Military	10	3	7	68	53	109
Toxic Shock syndrome	9	6	N	95	108	N
Tuberculosis	368	433	489	5,458	5,361	6,258
Tularemia	1	-	2	18	24	27
Typhoid fever	4	8	8	64	74	106
Typhus fever, tick-borne (RMSF)	2	5	5	18	19	22
Rabies, animal	110	107	158	1,400	1,302	1,579

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1986		Cum 1986
Anthrax	-	Leptospirosis	13
Botulism: Foodborne	3	Plague	-
Infant (Calif. 1)	15	Polioomyelitis, Paralytic	-
Other	-	Psittacosis	16
Brucellosis (Iowa 1)	14	Rabies, human	-
Cholera	-	Tetanus	11
Congenital rubella syndrome	1	Trichinosis	7
Congenital syphilis, ages < 1 year	11	Typhus fever, flea-borne (endemic, murine)	5
Diphtheria	-		

*There were no cases of internationally imported measles reported for this week.

Radiation Protection Regulations

A Summary

The Council on Health Care of the Canadian Dental Association has become aware that there are members of our profession who may not be cognizant of the regulations pertaining to radiation protection which exist in their province. In addition, the Council felt that the compilation of such material would be helpful to dental students who are about to graduate, to immigrant dentists, as well as to dentists who may be planning to move from one part of Canada to another. With this in mind, the Council decided to compile information from each of the Provinces and the N.W.T., concerning radiation protection. The summary provides an overview of what is required in each jurisdiction.

This material is not only meant to provide general reference information, but should also serve as a guide to alert members of our profession to these Radiation Protection Regulations. Dentists should, however, refer to their particular Provincial Regulations for specifics.

The following are Provincial and Federal addresses from which more specific information may be obtained:

- | | |
|-------|--|
| B.C. | Mr. Brian G. Phillips
Director
Radiation Protection Service
200 - 307 West Broadway
Vancouver, British Columbia
V5Y 1P9 |
| Alta. | Mr. P.J. Barrett
Manager
Medical X-ray Program
Radiation Health Branch
Workers' Health, Safety and Compensation
10709 Jasper Avenue
Edmonton, Alberta
T5J 3N3 |
| Sask. | Mr. L. Denis Brown
Chief Radiation Health Physicist
Occupational Health and Safety Branch
Saskatchewan Labour
Saskatchewan Place
1870 Albert Street
Regina, Saskatchewan
S4P 3V7 |
| Man. | Mr. A.M. Sourkes, Ph.D.
Head, Radiation Protection Section
Dept. of Medical Physics
Manitoba Cancer Treatment and Research Foundation
100 Olivia Street
Winnipeg, Manitoba
R3E 0V9 |

Ont.	Mr. J.H. Ritchie Chief, X-ray Inspection Service Ministry of Health 6th Floor 7 Overlea Boulevard Toronto, Ontario M4H 1A8
N.B.	Mr. Keith L. Davies Senior Radiation Physicist Radiation Protection Service Department of Health P.O. Box 6000 Fredericton, New Brunswick E3B 5H1
P.E.I.	Sister Noreen Hammill Radiology Manager Dept. of Radiology Queen Elizabeth Hospital P.O. Box 6600 Charlottetown, Prince Edward Island C1A 8T5
N.S.	Mr. T.E. Dalglish Senior Radiation Health Officer Radiation Section Department of Health P.O. Box 488 Halifax, Nova Scotia B3J 2R8
Nfld.	Mr. E.F. Price Executive Secretary Radiation Health & Safety Advisory Committee Occupational Health & Safety Division Department of Labour and Manpower P.O. Box 4750 St. John's, Newfoundland A1C 5T7
N.W.T.	Ms. Laurie Nowakowski Head, Occupational Health & Safety Section Safety Division Justice and Public Services Government of the Northwest Territories Yellowknife, Northwest Territories X1A 2L9
Health & Welfare Canada	Mr. Paul Chaloner Head, Inspection Unit X-ray Section Consumer & Clinical Radiation Hazards Div. Bureau of Radiation and Medical Devices Health Protection Building Tunney's Pasture Ottawa, Ontario K1A 0L2 753

	B.C.		ALTA.		SASK.	
1) Radiation Protection Act	No	(2)	Yes		Yes	
2) Regulations which apply:						
A) Before actual construction of a surgery	No	(3)	Yes		Yes	(7)
B) To renovations of existing rooms which already house x-ray equipment	No	(3)	Yes		Yes	(7)
C) To relocation of x-ray equipment to another room or within same room	No	(3)	Yes		Yes	(7)
3) Regulations for which the dentist is responsible and which apply:						
A) Before installation of x-ray equipment	No		Yes		Yes	
B) Before use of x-ray equipment	No		Yes		Yes	
4) Enforcement -						
Enforcement of 2) and 3) by federal or provincial authorities		n/a	Prov.		Prov.	
5) Inspections -						
A) Inspections carried out, which may be mandatory or voluntary						
1) Before construction	Yes	Voluntary	No		No	
2) During construction	"	"	No		No	
3) After construction	"	"	Yes	Mandatory	Yes	Mandatory
4) Before renovations	"	"	No		No	
5) During renovations	"	"	No		No	
6) After renovations	"	"	Yes	Mandatory	Yes	Mandatory
5) Follow-up Inspections (1)	Yes		No		Yes	(8)
1) Frequency	(4)		n/a		Yes	(8)
2) Mandatory or Voluntary	Voluntary		n/a		Yes	(8)
3) At whose request	Dentist		Regulating Body		Dentist	(8)
4) Performed by whom	Prov.		Prov. (6)		Prov.	
5) Is there a fee charged for inspections	No		No		No	
6) Revisions planned for 1987	Yes	(5)	Yes		Yes	

	MAN.	ONT.	QUE.
1) Radiation Protection Act	Yes	Yes	Yes
2) Regulations which apply:			
A) Before actual construction of a surgery	Yes	Yes	Yes
B) To renovations of existing rooms which already house x-ray equipment	Yes	Yes	Yes
C) To relocation of x-ray equipment to another room or within same room	Yes	Yes	Yes
3) Regulations for which the dentist is responsible and which apply:			
A) Before installation of x-ray equipment	Yes	Yes	Yes
B) Before use of x-ray equipment	Yes	Yes	Yes
4) Enforcement -			
Enforcement of 2) and 3) by federal or provincial authorities	Prov.	Prov.	Prov.
5) Inspections -			
A) Inspections carried out, which may be mandatory or voluntary			
1) Before construction	Yes Mandatory	Yes Mandatory (10)	Yes Mandatory
2) During construction	" "	" " (10)	" "
3) After construction	" "	" " (10)	" "
4) Before renovations	" "	" " (10)	" "
5) During renovations	" "	" " (10)	" "
6) After renovations	" "	" " (10)	" "
B) Follow-up Inspections (1)	Yes	Yes	Yes
1) Frequency	(9)	3-5 Years	2 to 3 Years
2) Mandatory or Voluntary	Mandatory	Yes	Mandatory
3) At whose request	Regulating Body	Regulating Body	Regulating Body
4) Performed by whom	Prov.	Prov.	Private Physicist
5) Is there a fee charged for inspections	No	No	Yes
6) Revisions planned for 1987	Yes	Yes	Yes

	N.B.	P.E.I.	N.S.
1) Radiation Protection Act	No (11)	Yes	Yes
2) Regulations which apply:			
A) Before actual construction of a surgery	No (11)	Yes	Yes
B) To renovations of existing rooms which already house x-ray equipment	No (11)	Yes	Yes
C) To relocation of x-ray equipment to another room or within same room	No (11)	Yes	Yes
3) Regulations for which the dentist is responsible and which apply:			
A) Before installation of x-ray equipment	No (11)	Yes	Yes
B) Before use of x-ray equipment	No (11)	Yes	Yes
4) Enforcement -			
Enforcement of 2) and 3) by federal or provincial authorities	n/a	Prov.	Prov.
5) Inspections -			
A) Inspections carried out, which may be mandatory or voluntary			
1) Before construction	Yes Vol. (11)	Yes Mandatory	Yes Voluntary
2) During construction	" " "	" "	" "
3) After construction	" " "	" "	" "
4) Before renovations	" " "	" "	" "
5) During renovations	" " "	" "	" "
6) After renovations	" " "	" "	" "
B) Follow-up Inspections (1)	No (12)	Yes	Yes
1) Frequency	n/a	Yearly	2 Years
2) Mandatory or Voluntary	Voluntary	Mandatory	Mandatory
3) At whose request	Dentist	Regulating Body	(13)
4) Performed by whom	Prov.	Prov.	Prov.
5) Is there a fee charged for inspections	No	Yes	No
6) Revisions planned for 1987	Yes	No	No

	NFLD.	N.W.T.
1) Radiation Protection Act	Yes	Yes (14)
2) Regulations which apply:		
A) Before actual construction of a surgery	Yes	(15)
B) To renovations of existing rooms which already house x-ray equipment	Yes	(15)
C) To relocation of x-ray equipment to another room or within same room	Yes	(15)
3) Regulations for which the dentist is responsible and which apply:		
A) Before installation of x-ray equipment	Yes	Yes (15)
B) Before use of x-ray equipment	Yes	Yes (15)
4) Enforcement -		
Enforcement of 2) and 3) by federal or provincial authorities	Prov.	Federal
5) Inspections -		
A) Inspections carried out, which may be mandatory or voluntary		
1) Before construction	Yes Mandatory	No (16)
2) During construction	Yes If feasible (20)	" (16)
3) After construction	Yes (20)	" (16)
4) Before renovations	Yes Mandatory	" (16)
5) During renovations	Yes (20)	" (16)
6) After renovations	Yes (20)	" (16)
B) Follow-up Inspections (1)	Yes	No
1) Frequency	2 years	(17)
2) Mandatory or Voluntary	Mandatory	Voluntary
3) At whose request	Dentist (19)	(18)
4) Performed by whom	Prov.	Federal
5) Is there a fee charged for inspections	No	No
6) Revisions planned for 1987	No	No

- 1) Follow-up inspections refer to those inspections carried out after the initial inspections which may be required in section 3 "Regulations", and section 5(a) "Inspections".
- (2) At present, there are no provincial regulations in place in British Columbia, governing radiation protection in any discipline using radiation sources. A cooperative relationship has been established with a number of the professional associations representing specific healing arts groups, e.g., British Columbia Dental Association, British Columbia Medical Association standards used are those developed by Health and Welfare Canada. Reference is made to Safety Code 22, radiation protection in dental practice. (Health & Welfare Canada 80-EHD-66).
- (3) Shielding designs are appraised and approved by Radiation Protection Service.
- (4) To assess the performance of dental x-ray units, the Radiation Protection Service uses a mail-out system utilizing thermoluminescent dosimeters for initial appraisal. If there are indications of any problems or abnormal results an inspection will be conducted by provincial personnel.
- (5) General radiation protection development under consideration.
- (6) When an inspection is carried out.
- (7) Approval for radiation shielding required.
- (8) Where possible provincial radiation health inspectors will always inspect on request if concerns arise. Repeat inspections initiated by Saskatchewan Occupational Health and Safety Branch depend on workload.
- (9) Every three years for on-site inspections and every year for mail-in thermoluminescent dosimeter.
- (10) Legislation requires the owner of the x-ray facility to ensure that installation of equipment is carried out according to previously submitted and approved plans. In this regard, the x-ray inspection service has authority to conduct random inspection visits to check compliance.
- (11) New Brunswick has no radiation protection act at the present time. All radiation protection is achieved on a voluntary basis. Through the New Brunswick Dental Society, dentists constructing or renovating surgeries are encouraged to submit plans to the Radiation Protection Service for approval but this is not a mandatory requirement.
- (12) The Radiation Protection Service inspects dental x-ray equipment. On request to the present there has been no systematic program of follow-up inspections.
- (13) Regulating body - Every 2 years, anytime by the dentist.

- (14) All Northwest Territories facilities are required to follow the radiation emitting devices regulations under the Radiation Emitting Devices Act. In the Northwest Territories, there is no territorial radiation inspection agency, and so all dental facilities are under the inspection requirements of the Radiation Protection Bureau of the Health Protection Branch of Health and Welfare Canada. When new facilities are planned, the owner is required to deal with Health & Welfare Canada directly the Head of Occupational Health and Safety, Northwest Territories, may act as liaison.
- (15) X-ray section of the Bureau of Radiation and Medical Devices supplies the necessary shielding requirements to the dentists and verifies the adequacy of shielding when the x-ray unit is inspected.
- (16) It is not practical for x-ray section to visit facilities during construction. If contractors have questions, x-ray section-Health & Welfare Canada will answer them. the x-ray equipment and facility is inspected as soon after installation as possible.
- (17) There are no mandatory requirements for reinspection. The facility may be revisited every four to five years.
- (18) The request for an inspection may come from either the dentist or the Northwest Territories government, or from x-ray section Health & Welfare Canada indicating that they will be in the area and asking if Northwest Territories government wishes an inspection done.
- (19) Responsibility of owner to see that survey of equipment is carried out every 2 years and report forwarded to regulating body.
- (20) If within practical distance of office of regulating body.

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

MEMBERS: Dr. J. H. Gryfe, Chairman, Ontario
Dr. C. Foster, Manitoba
Dr. J. Hardie, Ontario
Dr. J. V. Legault, Quebec
Dr. E. L. MacInnis, Nova Scotia
Dr. W. S. Walter, British Columbia

Dr. E. F. Allison, Executive Liaison

STAFF: Mr. Brian Henderson, Director of Education & Accreditation
Mrs. Lorraine Emmerson, Coordinator of Accreditation

1. Council Meeting

The Council has met once on June 12-13, 1987 since my last report to the Interim Board in April 1987. In attendance at this recent meeting was Dr. Dana Herberts replacing Dr. Walter who was unable to attend.

Items Requiring Board Action

2. Procedures for Oral Care of Chronic Care Patients - A Document for Health Care Workers - Part II

APP. 1

Part II of "Guidelines for Oral Care of Chronic Care Patients - A Document for Health Care Workers" has been reviewed by Council. The combination of this document with "Guidelines for Chronic Care Maintenance - Part I" which has previously be approved by the CDA Board will be forwarded to the Council on Information Services for consideration of methods of production and distribution as a complete package following approval of the CDA Board.

RESOLVED:

87.109 THAT the document "Procedures for Oral Care of Chronic Care Patients - A Document for Health Care Workers - Part II" be approved by the CDA Board of Governors for use as a Resource Document.

ADOPTED

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

3. Canadian Hospital Association

Recent negotiations between the Canadian Dental Association and the Canadian Council on Hospital Accreditation have identified an apparent need for direct communication with the Canadian Hospital Association to deal with a number of subjects of mutual interest. At a previous informal meeting with a representative of the Canadian Hospital Association it was indicated that a more formal meeting should be encouraged.

RESOLVED:

- 87.110** **THAT a meeting be arranged between senior representatives of the Canadian Dental Association and the Canadian Hospital Association to identify and discuss areas of mutual concern.**

ADOPTED

4. Minimum Level of Accreditation

Council identified the need to define a minimum level of accreditation acceptable for a newly accredited institutional dental service to be able to maintain a dental internship.

RESOLVED:

- 87.111** **THAT an internship or residency program at an institutional Dental Service must have achieved at least CONDITIONAL APPROVAL before it becomes eligible to be surveyed .**

ADOPTED

5. Minimum Life Support Guidelines

Council discussed the need for the development of guidelines that private offices or institutions might follow in order to be reasonably prepared for handling medical dental emergencies in institutions and/or private offices. The following is presented for Board approval:

RESOLVED:

- 87.112** **THAT to prepare for medical/dental emergencies in the office or institution, the following initiatives should be taken.**

- (1) Identify protocol for summoning the cardiac arrest team or external help.**

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

- (2) Ensure that personnel are trained in CPR and have a CPR board available.
- (3) Have positive flow oxygen available.
- (4) Have equipment to place patient in shock position available.

ADOPTED

6. Reciprocal Agreement - CDA/ODQ

Recent discussions between the Order of Dentists of Quebec and the Canadian Dental Association have suggested agreement on the principle of mutual acceptance of each other's agents when conducting hospital surveys in the Province of Quebec. Council feels that the cooperation and goodwill that now exists between the CDA and ODQ can only be strengthened by formalization of this approach.

RESOLVED:

87.113 THAT the Council on Hospital and Institutional Services supports the concept of a contractual agreement between the Order of Dentists of Quebec and the CDA for the purpose of conducting surveys of institutional dental services in the Province of Quebec; and,

 THAT Council agrees to accept the findings and recommendations contained in the report from the Order as being its findings and recommendations for that institution; and,

 THAT Council reserves the right to provide supplementary advice or comments to hospitals or institutions surveyed.

ADOPTED

Items for Information - Not Requiring Board Action

7. Standard Record Form

A standard record form for institutional use is being developed. It is expected that this will be available for Board approval at the 1988 Interim Board meeting.

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

8. Meeting with CCHA Acting Executive Director

APP. 2

A meeting was held on May 1, 1986 between the Chairman of the Council on Hospital and Institutional Services and Dr. Jennifer Jackman the Acting Executive Director of the Canadian Council on Hospital Accreditation. The formal application for membership by the Canadian Dental Association was discussed as well as other current concerns. It is anticipated that the application will not be acted upon until June 1989 at the earliest because of present disruptions in the Canadian Council on Hospital Accreditation. Continuing liaison in the interim is being encouraged by both organizations.

9. Correctional Services Canada

APP. 3

A meeting was held on May 26, 1987 between the Chairman of Council on Hospital and Institutional Services and the Chairman of the Health Advisory Committee to Correctional Services Canada, Dr. Don Rice to discuss the possibilities of (a) arranging a series of surveys of appropriate dental departments in federal institutions for the purpose of acquiring CDA accreditation and (b) creating a number of educational positions in these institutions that could support either a fourth year dental student and/or dental interns. A preliminary survey on September 2, 1987 at the federal institution at Stoney Mountain, Manitoba has been arranged to assess the viability of the discussions.

10. Survey Program Department of Veteran's Affairs

APP. 4

The survey program involving the Department of Veteran's Affairs facilities nationwide, has been concluded. A copy of the summation report is included. Special thanks is extended to Dr. Julian Tsafaroff the Senior Dental Consultant for the DVA and his staff for the cooperation and input during this survey.

11. Resource Letter

APP. 5

A "generic" letter has been developed to be used as an initial document of information for those institutions which maybe considering inviting the CDA survey process into their hospital complexes.

12. Resignation from Council

The Council Chairman, accepts with regret, the resignation of Dr. William Walter.

13. Survey Reports - Dental Services

The following Dental Services were approved by Council.

Baycrest Geriatric Centre, Toronto
B.C. Children's Hospital, Vancouver
Centre Hospitalier St-Mary's, Montreal
Doctor's Hospital, Toronto
Health Sciences Centre, Winnipeg
Hôpital Notre-Dame, Montreal
Montreal General Hospital, Montreal
Mount Sinai Hospital, Toronto
St. Michael's Hospital, Toronto
Sunnybrook Medical Centre, Toronto
Toronto Western Hospital, Toronto
The Hospital for Sick Children, Toronto
Rideau Veterans Home, Ottawa
Sunnybrook Medical Centre (Veteran's Affairs), Toronto
Vancouver General Hospital, Vancouver
Victoria General Hospital, Victoria
Victoria Hospital (Veteran's Affairs), London

14. Progress Reports - Dental Services

The following Dental Services progress reports were reviewed by Council and extended to correspond to the new five year term by Council.

University Hospital, London
St. Joseph's Hospital, London
Victoria Hospital, London
Janeway Child Health Centre, St. John's

15. Conclusion

The Chairman, in this his final report, wishes to extend to this Board his heartfelt thanks for their continuing advice and cooperation. In addition he wishes to gratefully acknowledge the incalculable assistance of the Coordinator of Accreditation, Mrs. Lorraine Emmerson and the limitless

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

- 6 -

support, direction and background of the Director of Accreditation, Mr. Brian Henderson.

Respectfully submitted,

J. H. Gryfe, D.D.S., Chairman
Council on Hospital and
Institutional Services.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Hospital and Institutional Services with appreciation.

The Board of Governors expresses its appreciation to the Council on Hospital and Institutional Services, particularly to the Chairman, Dr. Jack Gryfe, and the Coordinator, Mr. Brian Henderson, for their outstanding achievements.

PROCEDURES FOR ORAL CARE
OF
CHRONIC CARE PATIENTS

A Document for Health Care Workers

PREPARED FOR:

**CANADIAN DENTAL ASSOCIATION
CANADIAN DENTAL HYGIENISTS' ASSOCIATION**

July 14, 1986

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INTRODUCTION

The object of this booklet is to stress the importance of good oral and dental health in the medically compromised patient, and to describe basic oral hygiene techniques which may be taught to patients for self-care or to staff for those patients who are incapable of self-care.

Good dental and oral health contributes in no small way to good general health. Conversely, poor dental health and the inability to eat and drink properly can lead to digestive disorders, heartburn, indigestion, improper absorption and potentially malnutrition and decreased quality of life.

The techniques discussed in this booklet are simple and basic, bearing in mind that patient care personnel have many duties to perform for their charges during a busy day. In this respect obviously, the best and most expedient delivery of oral hygiene care is self-care, and every effort should be made to instruct those patients who are capable and ensure that such self-care is carried out properly. The more patients can do for themselves, the greater their self-esteem and sense of independence. Thus, for these individuals a program of instruction followed by supervision is ideal. Those patients who are unable to carry out their own oral health care will require either assisted care or will need to have their oral health care routine performed for them. Good oral hygiene is an important cornerstone in the promotion of good general health, well being and self-esteem, and thus must be given at least as much attention by staff as general hygiene care. The small amount of time spent in attending to oral hygiene care will contribute greatly to the quality of life for the patient.

As part of a good oral health care program, every long term care institution should have a dentist and also a dental hygienist appointed to its staff. Each new patient admitted to the institution should have an oral examination as part of the routine admission procedure. Any recommendations made following this oral examination should be carried out, and thereafter all patients should have an oral examination at least once a year.

NOTE: It is just as important that this routine be followed for edentulous patients (patients with no natural teeth) as it is for those with natural teeth.

CARE OF NATURAL TEETH

Plaque is a sticky, colorless, bacterial film which forms in the mouth and sticks to tooth surfaces. It can not be rinsed off. Plaque is responsible for causing cavities and gum disease (pyorrhea). It takes 24 hours for the bacteria to organize into harmful colonies. Reducing and disorganizing the colonies will make the plaque harmless. Therefore a thorough cleaning of all tooth surfaces at least once every 24 hours is essential.

BRUSHING

The use of a soft bristled nylon toothbrush and a fluoridated toothpaste is recommended. Brush all tooth surfaces; the outside, inside (facing the tongue), and the chewing surfaces of both top and bottom teeth, with the following brushing technique:

1. Place the brush on the side of the teeth at a 45° angle toward where the teeth and gums meet. The bristles of the brush should ease slightly under the gums (Figure 1).
2. Gently vibrate the brush back and forth in short, gentle strokes while keeping the brush angled against the gum line.
3. After vibrating the brush back and forth 4 or 5 times, roll the bristles away from the gums.
4. For the inside surfaces of the front teeth, tilt the brush so the tip of the brush is at the gum line and wiggle, moving over one tooth at a time (Figures 2 and 3).

5. Brush the tongue to remove germs and freshen breath.

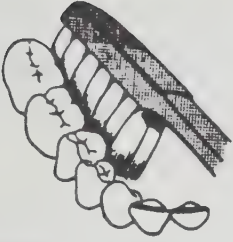


Figure. 1



Figure. 2



Figure. 3

An electric toothbrush may be a valuable device for someone having difficulty in using or grasping a regular toothbrush. It is recommended primarily for use by health workers.

FLOSSING

The toothbrush cannot clean between the teeth. Plaque on these surfaces can be effectively removed by using dental floss. A commercially available " floss handle " (Figure 4) fixes the floss between the two arms of the handle making it easier to floss effectively for both the individual and if necessary, the health worker. (These are available in the dental care section of drugstores or supermarkets.) The staff member can brush or floss the patient's teeth from behind or from the side. This will ensure optimum control over the patient and the toothbrush.



Figure. 4

RINSING

Commercial mouthwashes contain a high level of alcohol which may be very drying to the oral tissues. When mouthwashes are used, they should be diluted at least half and half with water.

In the geriatric population, root caries (decay on the root surface), is common. FLUORINSE .05% (daily rinse) is available without prescription and will protect the surfaces or slow the decay process.

Chlorhexidine, an antiseptic, has proven to be effective in inhibiting plaque formation and is available by prescription only. As an alternative to obtaining a prescription, a taste-acceptable solution can be made by mixing a 750 ml bottle of Cepacol mouthwash with 37 ml of Hibitane Skin Cleanser (Both are available at local drug stores).

NOTE: The cap of the Cepacol bottle holds approximately 40 ml . Almost filling the cap will provide the proper amount of Hibitane.

This solution should be used daily. Long term use may stain root surfaces and plastic restorations. However, the advantages of Chlorhexidine rinse in preventing dental decay, generally outweighs the aesthetic considerations. The rinse should be used in addition to daily brushing and flossing.

LIP CARE

Lips may become chapped, cracked or sore for a variety of reasons such as drooling, angular cheilitis (see Section VII), or prolonged exposure to wind or sun. This is best treated with lanolin cream or a PABA - containing lip balm.

MOBILE TEETH

Teeth which have lost supporting bone due to periodontal disease (gum disease, pyorrhea) become loose over a period of time. Once bone is lost, it can not be replaced. Mobile or loose teeth create difficulty in chewing, swallowing and speech, and are more difficult to clean properly. If the patient has several "loose" teeth, there is a tendency for him/her to favour softer foods. Ultimately, this may result in other nutritional problems. If the tooth is extremely mobile, there is a danger of swallowing or aspirating the tooth, and therefore a dentist must be consulted for appropriate treatment.

HALITOSIS (BAD BREATH)

Halitosis (bad breath) is most commonly a sign of poor oral hygiene and therefore is quite easily controlled through proper cleaning of the oral cavity. Persistence of halitosis may indicate chronic digestive or lung disease.

ORAL HYGIENE KITS

It is advantageous to classify the patient population within the following 4 categories and to prepare prepackaged and identified Oral Hygiene Kits for each group. This will simplify oral health care for both patients and staff. It is most important that each patient has his/her own Oral Hygiene Kit.

1. ALL NATURAL TEETH

- soft bristle toothbrush - brush daily
- fluoridated toothpaste
- dental floss (with or without floss holder)

2. COMBINATION (natural teeth with partial dentures)

- soft bristle toothbrush - brush daily
- fluoridated toothpaste
- dental floss (with or without floss holder)
- denture brush - brush daily
- clasp brush (for partial denture)

3. FULL DENTURES

- denture brush - brush daily
- soft bristle toothbrush (or washcloth) for massaging gums and palate - brush daily.

4. NO DENTURES/ NO NATURAL TEETH

- soft bristle tooth brush (or washcloth) for massaging gums and palate - brush daily.

IMPORTANT: Once the bristles on a toothbrush begin to curl outwards, it is ineffective and must be replaced.

TOOTHBRUSH ADAPTATIONS

Toothbrush adaptations can easily be made to allow the patient who has difficulty holding or manipulating a brush. Eg. arthritis, limited arm movement or central nervous system disorders, to maintain his/her own oral hygiene.

An oversized handle may allow easier control and facilitate grip. The handle of a toothbrush may be embedded in a bicycle handlebar grip. The handle of either a toothbrush or denture brush can easily be inserted into a styrofoam ball (Figure 5).

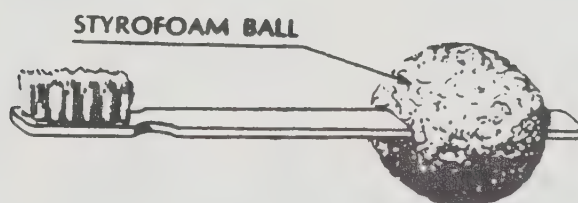


Figure 5

The handle of a toothbrush can be made longer for the patient with limited arm movement by cutting off the bristle portion of an old toothbrush and attaching the remaining handle to the handle of a new toothbrush with a strong cement. Alternatively, a tongue blade may be taped to the handle of a toothbrush (Figure 6).



Figure 6

For the patient who can not grasp and hold, a velcro strap around the hand with a slit on the palm side to insert the toothbrush handle may be used (Figure 7).

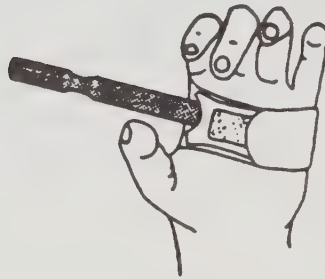


Figure 7

Suction cups can be attached to the bottom of a nail brush or denture brush (Figure 8). This allows the brush to be attached to the inside of the sink to keep it from slipping. This aids the patient with one hand or the patient who needs to grasp the dentures with 2 hands in avoiding from dropping and breakage of the denture.



Figure 8

ORAL HYGIENE FOR THE SEVERELY COMPROMISED PATIENT

THE BEDRIDDEN PATIENT

Maintenance of oral cleanliness for the bedridden or unconscious patient requires special procedures in order to clean the mouth, minimize the possibility of infection and provide comfort for the patient.



If the patient is confined to bed, place the patient on his/her side when he/she can not be placed in a sitting position. (Figure 9). Use pillow to elevate head, place a bath towel under the patient's cheek and over the side of the bed, and place a basin on the bath towel beside the patient's cheek. Have suction available.

Figure 9

THE UNCONSCIOUS PATIENT

For the unconscious patient with natural teeth, an electric toothbrush may be more efficient and easier for the attendant to use. A mouth prop can be placed in one side of the mouth while retracting the other. An assistant for suctioning is a necessity unless a commercially available suction brush is used.¹ A lubricant such as equal parts lemon juice and pure glycerin should be applied to the oral mucosa and lips regularly.

When a patient who wears complete or partial dentures is unconscious, the dentures should not be worn but stored in water in a covered container. The unconscious patient's head should be placed to one side and the gums wiped with a clean damp washcloth or gauze daily.

THE UNCOOPERATIVE PATIENT

The most important step in brushing an uncooperative patient's teeth is having control of their head. The patient should be seated in a chair in front of the attendant. This allows the attendant to approach from behind and clasp the patient's head to his/her body with the nonbrushing arm, taking the patient's chin in the hand (Figure 10).



Figure 10

¹ Aspir - Brush available commercially
Ray Graham Association for the Handicapped
Grand Oak Office Center
970 North Oaklawn Ave. (Suite 300)
Elmhurst, Ill. 60126

Such a firm but loving head-hug will increase toothbrushing effectiveness and decrease the possibility of toothbrush trauma because this position closely resembles the attendant's own normal brushing position while keeping the head still.

If the patient is fighting with their body as well as their head, have them lie on a bed or couch with their head in the attendant's lap (Figure 11). In this case, a second person may be needed to help control the body. Certain extremely uncooperative patients may require suitable premedication.

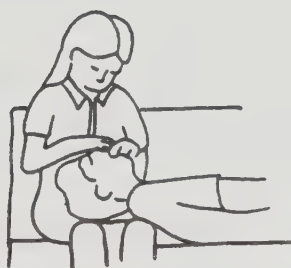


Figure 11

When using the head-hug position, opening the mouth is simple. Just tuck the thumb of the head-hug hand between the lower front teeth and lower lip and grasp the chin with the rest of the fingers. Gently push the inside of the lower lip down, use the thumb and index finger of the other hand to wedge the front teeth apart. Once mouth opening has been achieved, maintain the hold on the chin and inside lower lip, and use the other hand for brushing.

CAUTION: The attendant should use care to avoid being severely bitten by the uncooperative patient.

A mouth prop may be used with such patients, maintaining the mouth opening and preventing them from biting the attendant. These are commercially available or can be made by taping three tongue depressors together. At one end, wrap eight 2" X 2" gauze squares, four on either side. Wrap gauze securely with white adhesive tape (waterproof) until no gauze is visible and padding is well attached to the depressors. The mouth prop is used as a wedge and is held in the head-hug hand. Use the free hand thumb to apply a downward push to the inside lower lip, and insert mouth prop between the back teeth. Be sure to maintain head-hug, throughout this procedure.

The main area of concern when brushing is the gum line. Therefore, even though the technique may not be perfect, by concentrating efforts on this area, the most crucial area of the mouth will be cleaned. If visibility is a problem in the mouth, limit the use of toothpaste until the toothbrushing technique is perfected.

IMPORTANT: Make this time as pleasant as possible for the patient. Talk soothingly throughout the procedure, explain what is to be done and constantly encourage the patient. Be gentle and caring. With time, the uncooperative patient may learn to accept this procedure with more tolerance.

CARE OF DENTURES

Dentures are part of the patient and like all aspects of his/her being, they require care, concern and cleansing. A daily routine of hygiene will keep the smile bright, countenance natural-looking and breath odor-free.

BRUSHING

a) Full Dentures

A denture brush, available in most drug stores, is specially designed to perform an effective job. Its shape will allow the cleaning of plaque and food debris from all surfaces — the inner part that rest on the gums, the outer surfaces next to the tongue and cheeks, and the teeth themselves. All parts of the denture should be brushed after each meal, if possible, but certainly thoroughly at the end of each day (Figure 12).

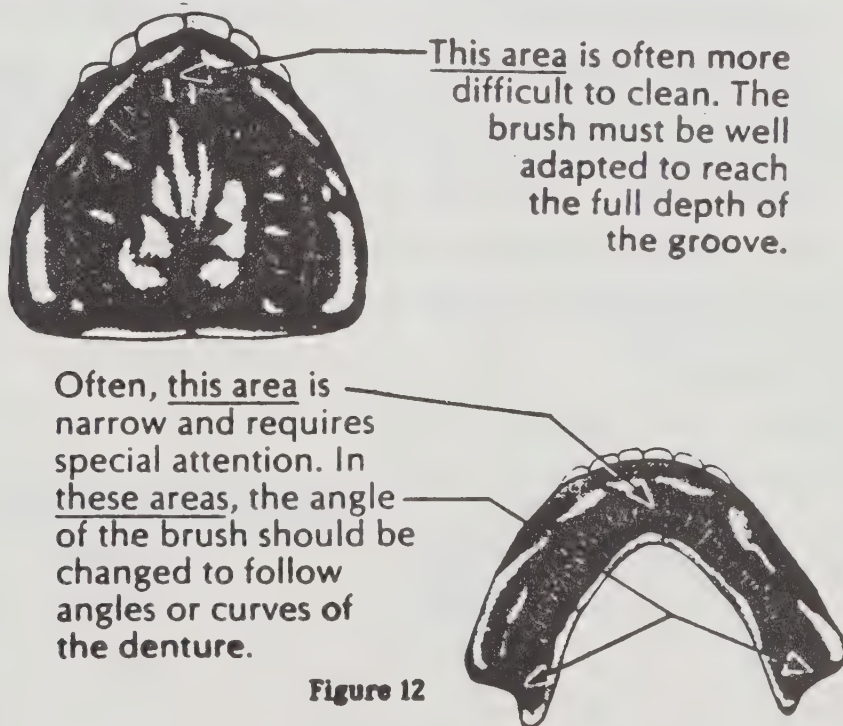


Figure 12

CAUTION! Dentures are breakable. It is best to place a washcloth in the sink and fill half - full of water. Hold the denture over the water while brushing so that if the denture slips from the hand, it will not break.

A commercial powder or paste such as "Dentu Creme" or ordinary toothpaste can be used to clean dentures. Liquid detergent such as "Joy, Ivory, Sunlight", baking soda or hand soap are also effective.

- IMPORTANT :**
1. NEVER use abrasive cleaners such as "Ajax" - they are just too harsh on denture plastic.
 2. NEVER soak dentures in bleaches such as "Javex".
 3. NEVER soak dentures in alcohol.

b) Partial Dentures

Good oral hygiene is MOST important to help maintain the health of remaining natural teeth and oral tissues. The partial should be taken out after every meal (if possible) and brushed with a denture brush to remove material stuck to it. A partial is attached by metal clasps (clips) to remaining natural teeth for retention. Plaque on the clasps of partial dentures cause decay of the teeth to which they are attached, therefore a daily thorough cleaning of the clasps (inside as well as outside) using a clasp brush must be carried out (Figure 13).



Figure 13

Clean the natural teeth and gums with a soft-bristled nylon toothbrush. Always remove the partial when going to bed; clean it, and store it in water. (For further details on partial denture care consult "Care of Dentures" section).

c) Soaking

It is strongly recommended that all dentures be left out during sleeping hours and stored in water, in order to rest the tissues of the mouth . Dentures should never be allowed to dry out - they will warp. To keep dentures fresh and to prevent staining, a soaking solution such as "Efferdent, Ansodent, Polident", etc, may be used. Dentures should be brushed well and rinsed before soaking overnight, and re-rinsed in the morning before insertion in the mouth.

DENTURE STAINS AND DEPOSITS

It is not unusual for dentures to gather stubborn stains. Often the stain is not removed with routine brushing and soaking, and it may be necessary to consult the dentist for professional cleaning.

Inadequate cleaning of dentures may result in accumulation of a yellowish - white deposit called "TARTAR", which can no longer be removed by brushing or soaking. It can be removed by soaking the dentures overnight for 3 or 4 nights in an equal parts vinegar/water solution. This will soften the deposits enough so that it may be removed with a denture brush. The denture should be rinsed and brushed well after soaking in vinegar solution before replacement in the mouth.

DENTURE ADHESIVES

A loose denture is usually a sign of an ill-fitting denture. The use of an adhesive powder or paste, is normally not harmful in the short term and may make a denture more retentive on a temporary basis. If looseness persists, the dentist should be consulted. Long term use of denture adhesives may irritate the tissues.

CARE OF THE MOUTH

Gum tissue is tender and fragile and requires special care. To keep gums healthy use a soft toothbrush or fingers wrapped in a washcloth to massage the upper and lower gums in a circular motion once a day. The tongue should also be brushed or massaged daily.

For treatment of denture sores, rinse and gargle with warm salt water, (1/2 teaspoon salt in 1/2 glass of warm water) several times a day. The denture should be left out until healing is complete. If the sores persist for more than 3 or 4 days, a dentist should be consulted.

DENTURE IDENTIFICATION

Dentures become separated from their owners for a variety of reasons. They are frequently left on meal trays, lost in the linen or mixed up by nursing staff cleaning dentures for several patients at the same time. Denture identification is simple and helpful to both staff and patients.

To avoid the problem of lost or misplaced dentures, some method of marking of patients dentures should be done routinely following admission. A denture-marking kit (Identure ²) is commercially available and convenient to use. Alternately, consult the staff dentist for assistance.

² Denture Marking Services
Sterling Marking Products
349 Ridout Street North
London, Ontario N6A 4K3

NUTRITION

Medically compromised patients frequently have concomitant poor oral health. Where chewing ability is decreased, low-nutritional, high sugar foods are often selected leading to nutritional deficiencies and increased susceptibility to disease. Plaque in the mouth mixes with carbohydrates (sugars and starches) in the foods one eats and forms acid. This acid then dissolves the tooth enamel causing decay. In addition, the intake of certain drugs may alter the absorption of nutrients. Therefore, balanced diet-planning must be undertaken as an important part of comprehensive care for this group.

To maintain a healthy status it is essential that these patients receive adequate nutrients from each of the four food groups as outlined in Canada's Food Guide: breads and cereals, milk and milk products, fruits and vegetables, and meat, fish, poultry and alternates. All too often, certain foods may be chosen due to their soft texture and ease of chewing. Fruits, vegetables, and meats frequently are avoided due to difficulty in chewing. Constant consumption of soft, mushy, foods may affect the digestive system, cause constipation and indigestion, decreasing the variety of foods selected, and making meals monotonous and unappealing. Avoidance or low consumption of milk and dairy products affects the bones including the jaw. As bone slowly breaks down, in the denture wearer, the denture will become loose, and "denture sores" may develop. Other problems that may be associated with nutritional deficiencies include swelling and inflammation of the tongue, and cracking at the corners of the mouth.

The care provider can play a key role in ensuring that nutritional requirements are met to maintain oral and general health:

- 1) Accommodate the "soft" diet by including nutritious, easily chewable foods such as cooked, finely chopped or shredded fruits and vegetables, ground meats, cottage cheese and increased use of milk products.
- 2) Increase the fibre content of the diet by using wholewheat bread and cereals including bran.
- 3) Consult with patients' physicians to determine if any prescribed drugs affect digestion of food and/or absorption of nutrients.
- 4) Attempt to make meals flavorful without excessive use of fat, sugar, and salt.
- 5) Select snacks that are of nutritional value.

Foods which can cause problems are :

- 1) Peanut butter sticks to the oral tissues and can cause obstruction in the disorientated patient and is therefore inadvisable.
- 2) Canned Peach halves are large and by their shape can act as a "suction cup" and cause obstruction in the disorientated patient. Use sliced peaches.
- 3) Spaghetti - slippery and easily aspirated. Cut up into "bite size" pieces.
- 4) Dry toast - hard and can cause obstruction.

COMMON CONDITIONS OF THE MOUTH

It is important for non-dental health care personnel to be able to recognize what is normal and abnormal in the mouth. Specific diagnosis and treatment should be made by the dentist. A knowledge of the more common lesions of the oral cavity should increase the awareness of the value of regular examinations for those who are in daily contact with institutionalized patients. This will ultimately lead to better oral health for the patient.

1. White Lesions

- a) Lichen Planus - This may be asymptomatic or in the case of erosive lichen planus, cause a painful, burning sensation in the mouth. It manifests as a white, lace-like formation on the mucosa of the cheeks or gums often with an underlying reddish base. This is usually harmless .
- b) Leukoplakia - Presents as a whitish, thickened area on the oral mucosa, is usually painless and often takes on the appearance of folds or "waves on the ocean". Commonly seen in smokers and heavy drinkers. This lesion is often a precursor of oral cancer and must be biopsied to rule out early cancerous changes.
- c) Squamous Cell Carcinoma - Often painless, arising on any oral mucosal surface. Appears as a white ulcerated lesion on a reddish base with rolled, raised edges and is often fixed to underlying tissues.

- d) Moniliasis or "Thrush" - Common in denture-wearers. This is a fungal (candida) infection and presents as a red inflammatory surface under the denture and may also present as superficial white raised patches (the fungus) on other oral mucosal surfaces in the elderly. The white patches can often be wiped off with gauze to leave a raw bleeding area underneath. This condition is usually painful and burning.

2. Angular Cheilitis

Common among edentulous elderly individuals. Seen as cracking and fissuring at the corners of the mouth. Often due to overclosure of the jaws (caused by unsatisfactory dentures or absence of dentures), producing excessive folding which becomes continually wet with saliva and secondarily infected with candida, staphylococci or streptococci.

3. Fordyce's Spots

Small yellowish spots usually seen on the mucosa of the cheeks, sometimes behind the lower molar teeth and on the inner surfaces of the lips. These are sebaceous glands and are asymptomatic and harmless.

4. Xerostomia (Dry Mouth)

The usual complaint is pain and burning. This can be due to atrophy of the salivary glands in the elderly and is also common in post-menopausal women. Dry mouth most often results from certain drug therapies such as antidepressants, antihypertensives and diuretics. The dentist may suggest the use of artificial saliva.

5. Hyperalivation (Drooling)

This may cause irritation or sores around the lips and chin.

6. Aphthous Ulcers

Very painful, usually occur in crops and appear on the tongue, cheeks or gums. Present as small punched-out greyish-yellow lesions with a red inflammatory base. These will usually disappear in 7 - 10 days.

7. Denture Hyperplasia

Usually the result of ill-fitting dentures. The tissues of the vestibule of the mouth are thrown up into a series of deep ridges and folds often accompanied by ulceration.

8. Migratory Glossitis or Geographic Tongue

The tongue literally has the appearance of a map with reddish smooth areas and patches outlined by whitish margins. Usually asymptomatic and harmless.

9. Atrophic Glossitis

Smooth, shiny, enlarged, red tongue. Can be painful, burning and may be due to a vitamin B₁₂ deficiency, folic acid deficiency and pernicious anemia.

10. Black Hairy Tongue

The dorsum of the tongue appears brownish or black and "hairy" due to elongation of the papillae. May be a side-effect of certain drug therapies, eg. tetracycline.

11. Tori

Bony "lumps" or eminences found most commonly in the roof of the mouth and/or on the inside of the lower jaw near the bicuspid teeth and vary greatly in size. These are usually of little consequence, though the thin mucosa covering them may sometimes ulcerate resulting in pain. Removal of the torus is then indicated.

12. Loose Teeth

Most commonly a result of loss of supporting bone (periodontitis or pyorrhea), but occasionally indicative of more sinister bone disease such as carcinoma or malignant lymphoma. Loose teeth should never be ignored.

Detailed or lengthy discussion of oral pathology is beyond the scope of this booklet. However, regular oral examination of patients by staff should be carried out and any perceived changes or abnormalities should immediately be referred to a dentist for further investigation.

ACKNOWLEDGEMENTS

This document has been prepared and edited by:

Dr. Colin Foster, BDS, MSc, FRCD(C) (Canadian Dental Association)

Yvonne Knazan, BA, RDH (Canadian Dental Hygienists' Association)

Grateful thanks to the following for their valuable contributions:

R. Crawford, DMD	(Past President, Canadian Dental Association)
D. Edmonds, RDH	(University of Manitoba, Faculty of Dentistry)
R. Plett, RDH	(Dental Health Services, Province of Manitoba)
M. Pilley, DMD	(Deer Lodge Centre)
P. Simpson, RDH	"
W. Rohalsky, DMD	"
S. Steinberg, MD	"
S. Beaulieu, RN	(St. Norbert Nursing Home)
G. Irvine, RN	"
M. Persaud, RN	(Seven Oaks Hospital)

APPENDIX 2



Canadian Council Conseil Canadien
on Hospital Accreditation D'Agrément des Hôpitaux

1815 Chemin Alta Vista Drive, Ottawa, Ontario, Canada K1G 3Y6
Telephone (613) 523-9154

April 13, 1987

Dr. John R. Robertson
President
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario
K1G 3Y6

Dear Dr. Robertson:

My apologies for the delay in responding to your letter of February 18, 1987. Your correspondence was rather timely in that it allowed me to bring the request for CDA membership on the CCHA Board of Directors to a meeting of the Board on March 13, 1987.

A number of professional organizations which do not currently hold a seat on the Council's Board of Directors have recently applied for a seat or have indicated an intention to do so. In view of this situation and considering other factors, the Board has identified the need to review its Mission and then its future composition. This review will be conducted, at least in part, at a retreat which will be scheduled in late 1988. Until such time as this matter is thoroughly discussed, the CCHA has chosen to defer consideration of applications for additional seats on the Board.

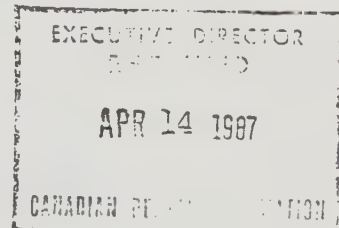
The resolutions of the Council on Hospital and Institutional Services following the 1985 Annual Meeting of the CDA Board of Governors have been noted. Further consideration of these resolutions by the CCHA will be deferred until at least late 1988 in conformance with the above-mentioned decision of the CCHA Board of Directors.

I would be pleased to discuss this matter further with you if you so desire. Please feel free to contact me at your convenience.

Sincerely,

Jennifer Jackman, M.D., C.C.F.P., M.B.A.
Interim Executive Director

JJ/wam





CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

M E M O R A N D U M

TO: Mr. A.J. Neilson, Executive Director
Dr. A. Schwartz, Chairman, Education & Accreditation
Mr. Brian Henderson, Director, Education and Accreditation
c.c. Board Book, Council Report
c.c. File

FROM: Dr. J.H. Gryfe, Chairman
Council on Hospital and Institutional Services

DATE: June 4, 1987

RE: Meeting between Dr. Donald Rice, Chairman, Medical & Health Care
Advisory Committee for the Correctional Services Canada and Dr.
J.H. Gryfe, Chairman, Council of Hospital and Institutional Services,
held May 26, 1987 in Toronto

Meeting took place at the request of Correctional Services Canada to exchange information regarding a possible implementation of an internship for dental training program involving the facilities of the Correctional Services of Canada. During the course of the meeting Dr. Gryfe outlined to Dr. Rice the mechanism of survey for accreditation for both the dental facility and subsequent dental internship or graduate program. Dr. Rice seemed quite enthusiastic about the possibility of pursuing such a program. After discussion it was identified that the Correctional Services facilities need not be in the same city as a university dental school as long as the geographic area around the Correctional Services institution would be able to supply appropriately qualified dental personnel. It was identified after much discussion that there were possibly appropriate institutions for this program in all parts of the country except in Atlantic Canada. It was agreed that at present there is no way of judging the appropriate installation in any of the Correctional Services without some sort of survey mechanism.

The following plan was agreed upon by Drs. Rice and Gryfe:

1. A presentation would be made to the Medical and Health Care Advisory Committee to be forwarded to the Correctional Services Canada that a sample survey be undertaken to assess present dental facilities in a major correctional services institution.

2. The site of this sample survey would be the maximum security institution near Winnipeg Manitoba.
3. If agreed upon this site survey would take place on the 2nd of September 1987 and the team surveying this facility would include Dr. Rice and Dr. Gary MacDonald representing the Advisory Committee and Dr. Gryfe and Mr. Henderson representing the Canadian Dental Association.
4. Should this facility, which is felt to be representative of the facilities across Canada, be considered potentially useful then a survey program similar to the recently completed program involving the Department of Veterans Affairs would be planned as a means of developing a series of accredited dental services in federal correctional services institutions.
5. With the onset of this formal program negotiations would be started with the Council on Education and Accreditation to draw up appropriate guidelines for the creation of internships in the accredited facilities.
6. The Correctional Services Canada and the Canadian Dental Association would work together to develop appropriate guidelines for future reference related to dental services in similar institutions.

Dr. Rice will be taking this proposal forward to the Medical and Health Care Advisory Committee to Correctional Services Canada at their next meeting on the 28th and 29th May, 1987 in Ottawa. He will inform me by phone shortly thereafter as to the results of this proposal and appropriate plans will be carried forth following this advice

JHG:dh



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

Dept. of Veterans Affairs - Canadian Dental Association Survey Program

Purpose

The DVA had stated that they had "mainly been concerned with the development and implementation of a geriatric dental program designed to meet the needs of our aging clientele." The CDA had stated that it "wishes to establish and standardize a level of dental care, especially within nonacute care institutions, that will reflect the quality of life we believe our geriatric population deserves." It was hoped that this joint program would be beneficial to both parties.

Method:

The method of survey and accreditation assessment was similar to the protocol that CDA has used successfully for the past three decades. An on-site team was sent to inspect the facility after preliminary questionnaires had been submitted, and following the report of the survey team to the Council on Hospital and Institutional Services, an appropriate status designation was granted. A copy of the recommendations was forwarded to the Senior Dental Consultant for DVA, Dr. Julian Tsafaroff.

The recent conclusion of this co-operative Survey/Accreditation program included DVA Dental Facilities in all regions of the country. These included :

- a) Royal Jubilee Hospital - Victoria, B.C.
- b) Shaughnessy Hospital - Vancouver, B.C.
- c) Deer Lodge Hospital- Winnipeg, Man.
- d) Westminster Hospital - London, Ont.
- e) K Wing, Sunnybrook Hospital - Toronto, Ont.
- f) Rideau Veterans Home - Ottawa, Ont.
- g) Queen Mary Hospital - Montreal, P.Q.
- h) Regional Clinic - Halifax, N.S.

In all instances, the facility staffs were most cordial and their frankness contributed to a useful exchange of ideas.

Findings:

The facilities reflected a curious mix of the attempts by DVA to maintain a program of care for those eligible veterans in geographically proximated institutions and those veterans able to reach a facility on an out-patient basis in Western and Central Canada; whereas in Quebec and Atlantic Canada, the institutionalized patient received care either on a more intermittent basis or by contract agreement with a university.

Dept. of Veterans Affairs - Canadian Dental Association Survey Program

All of the institutional dental facilities were well designed and equipped to manage the medically compromised patient. Treatment modalities were current and the levels of both concern and care reflected a genuine bond with the patient group they were treating. Certain shortcomings in record keeping and sterilization techniques recurred in virtually all of the clinics surveyed, but these findings were deemed to be easily correctable. A considerable variation in the type of medical emergency equipment kept in the departments reflected the absence of a policy in this area.

The professional staffs all voiced considerable frustration at the cutbacks in support personnel (dental hygienists, lab technicians), the reduction in technical facilities and materials in their departments and the policy of not replacing retiring dentists. More than one dentist felt that the increasing use of private sector practitioners was encouraging even greater reductions in the clinic-based scope of practice and this would soon create severe problems in treating the medically compromised veteran who cannot be treated in a private dental office.

Conclusions:

The level of care and the facilities provided, ensure that the veterans of Canada are being well served. The medically compromised veteran appears to have a more difficult time acquiring the same amount of dental care in those regions where the institutional dental clinic is being phased out. The irony of this lies in the realization that the bulk of Canada's veterans are now reaching 65 years of age, and the significant increase in the eligible veteran population will double to about 300,000 people by 1991. It appears, therefore that an important part of this geriatric group will have increasingly more difficulty in obtaining treatment as their numbers increase and the available facilities decrease in the next decade.

Those facilities that have been surveyed and accredited will probably treat decreasing numbers of patients in the latter half of the 1990's. By the year 2000, their reduced patient load, geographic location and established mode of treatment will make them ideal centres for other geriatric dental treatment considerations.

This program has supplied, to the Canadian Dental Association, a treatment model to help develop standards of care for both medically compromised and healthy geriatric citizens. The study has accentuated the need for CDA to develop new documentation if it wishes to extend the accreditation program into geriatric care facilities in a meaningful way.

Dept. of Veterans Affairs - Canadian Dental Association Survey Programs

The DVA Dental Services that have received accreditation should be considered as potential participants in any enlarged Prelicensure Program.

Continued co-operation between DVA and CDA will ensure that expertise available in both organizations will nurture the development of a creative and functional policy for the dental treatment of the increasing number of Canadians over the age of 65.

JHSe DDS FRCD(C)



APPENDIX 5

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

Dear:

Thank you for your request for information on the Canadian Dental Association Accreditation process. I am pleased to respond.

The dental profession recognized two decades ago that the field of hospital and institutional dentistry was expanding. More and more frequently, Dentists were treating medically-compromised patients in facilities provided within hospitals and dental service departments were being established. The Canadian Dental Association recognized both a need to provide assistance and resources to dentists establishing these new departments and an obligation to contribute to the assurance of quality control in the operation of these departments.

The medical profession, as I am sure you are aware, followed a similar path much earlier in establishing the Canadian Medical Association Council on Hospital Accreditation. This CMA Council subsequently grew into the Canadian Council on Hospital Accreditation.

CDA is currently negotiating with the latter for dental representation on its Board of Governors and for the establishment of CCHA Standards for dental service departments in hospitals and institutions. We anticipate success in these negotiations and the integration of our accreditation process, for the larger part, within CCHA's process.

/2

One condition, which CCHA understands, is that the first accreditation survey of a dental service would be carried out by a team of dental professionals. Subsequent surveys would be conducted by regular CCHA teams.

We set such a condition (and we are involved in our current accreditation process) because dental services, in many hospitals, do not compete very successfully with medical departments for necessary resources, and are often operated by dentists who are not fully familiar with the institutional setting and the special concerns of hospital/institutional dentistry. Many departments are operated like private practices and insufficient attention is paid to quality assurance, records, infection control and a number of other concerns which are reflected in our standards.

The survey, in my opinion, would benefit the hospital by subjecting the dental service to an external peer review process that should help identify both strengths and points of weakness or concern and assist improvement.

Our survey process provides dental services meeting national standards with a certificate of accreditation. This certificate indicates to the public that the department has met national standards. Dental services affiliated with Faculties of Dentistry must also possess such a certificate to be eligible to accept dental residents or student rotations. The need for qualified affiliated departments is continually growing.

The accreditation fee is \$850.00 and the regular term of accreditation is five years, so that the cost, calculated on an annual basis is equivalent to \$170.00 per year. If negotiations with CCHA are successful, following such an initial survey no further separate costs would be incurred.

I strongly believe in our process and its value to hospital or institutional dentistry. If I can provide additional information or clarify any points in my letter, please do not hesitate to contact me.

Kind regards,

Respectfully yours

Chairman
Council on Hospital & Institutional Services

COUNCIL ON INFORMATION SERVICES

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. Y. Kamachi, Chairman
Dr. R. Howaniec, B.C.
Dr. W.T. Koltec, Manitoba
Dr. G. Lafrenière, Québec
Dr. P. O'Brien, Nfld.

Executive Liaison: Dr. K. Roach, Ontario

1. Council Meetings

The Council has met once since the last Board, on June 8, 1987. Mr. Mark Sarner was a guest at this meeting.

ITEMS REQUIRING BOARD ACTION

2. 1988 DAP/DHM Budget

Further to the motion passed by Council in June 1987 for continuation of the Dental Awareness Program by Manifest Communications for a further two year term, Council reaffirmed its commitment to the DAP and recommended an expenditure of \$250,000 in 1988. The Council on Information Services recommends:

RESOLVED:

87.114 THAT a budget of \$225,000 be accepted for continuation of the Dental Awareness Program in 1988.

NOTE: Approved as amended from \$250,000 to \$225,000.

ADOPTED

In keeping with the traditional practice of dividing these dollars between dental health month activities and the DAP, \$75,000 was allocated to DHM and \$175,000 to DAP.

COUNCIL ON INFORMATION SERVICES

3. Pamphlet Program

Further to a decision at the April 1987 CDA Board to revamp CDA's pamphlet program, CDA's current pamphlets are being stocked on a limited basis while market research is being undertaken and fact sheets developed to replace certain dated materials. In addition, a plan to better promote and display CDA's pamphlets is also being developed. It is anticipated that the first phase of new pamphlets and fact sheets will be available this fall.

Council spent considerable time discussing the current demand for new pamphlets in areas such as fluoridation, pit and fissure sealants and care during pregnancy.

Considerable debate developed on the advantages and disadvantages of a pamphlet on Sepsis Control in the Dental Office as it relates to AIDS, Hepatitis B and Infection Control. Certain members of Council felt very strongly that CDA has a responsibility to both the public and the profession to develop such a pamphlet and promote certain infection control procedures. Other members of Council felt that the state of the science is changing so rapidly that anything CDA publishes will be outdated and subject CDA to a potentially liable situation.

Council seeks Executive Council's direction on this matter.

It is further noted that the successful CDA/Oral B Brochure has been incorporated into CDA's pamphlet inventory. To date over 221,000 English and 38,000 French brochures have been sold with CDA accruing over \$28,000 in revenue.

It is also anticipated that the Consumers' Guide to Dental Care will be incorporated into CDA's pamphlet program inventory in the near future.

4. Press Clipping Service

Council spent considerable time discussing both the cost and value of distributing clippings to the Executive Council and Board, Provincial Directors and DHM Chairmen.

Although the clipping service has provided an opportunity to measure the impact of the DAP in the print media, and an opportunity for the provinces to measure their own coverage and identify issues across the country, it is a very costly and time-consuming service to provide. CDA currently distributes over 60 copies of the sorted clippings on a semi regular basis three to four times per year. This service currently costs over \$6,000.00 per year.

COUNCIL ON INFORMATION SERVICES

Due to both the costs and time involved in sorting, processing and distributing the clippings, Council has decided to re-evaluate its usefulness by polling recipients on their utilization of the service, and on their willingness to pay for such a service and/or their desire to pare down the service to policy issues only.

Council will report on its findings at the April 1988 Board.

RESOLVED:

87.115 THAT the Press Clipping Service be discontinued.

ADOPTED

ITEMS NOT REQUIRING BOARD ACTION

5. Dental Health Month 1987

Council notes the success of 1987 dental health month activities. Materials sold in 1987 as compared to 1986 are as follows:

	<u>1986</u>	<u>1987</u>
Planning Kits	1200	294
Supplement to the Planning Kit	nil	1162
Chatelaine Check-up	99,582	21,748
Posters	16,005	24,296
Decals	147,500	79,730
Buttons	38,500	42,407
Cassettes	58	170
Revenue Accrued to DHM	\$27,624	\$42,683

These figures represent materials that were sold by CDA, not those that were distributed gratis for promotion purposes. As is always the case, receipt of these materials by the provinces in a timely fashion is always a priority but not always possible since both the supply and demand for materials vary from year to year.

COUNCIL ON INFORMATION SERVICES

Council requests Executive Council approval to proceed as follows:

That DHM materials be ordered immediately following provincial approval and well in advance of the February distribution date so that orders may be met without further delay. Orders should be made in quantities similar to those required during the previous year's campaign.

In addition, it would appear that the public service radio cassette entitled "Bob's Teeth" received enthusiastic support by both DHM organizers and local radio stations. Although CDA does not receive reports from all radio stations airing public service DHM radio spots, the following broadcasts were reported during April:

North Bay, Ontario	- 30 spot announcements
Kitchener, Ontario	- 11 spot announcements
Kirkland Lake, Ontario	- 19 spot announcements
Victoria, B.C. - CKDA	- 92 spot announcements
- CFMS	- 60 spot announcements

The Council was also encouraged by reports received from communities on their DHM activities. One report in particular captured Council's attention: the DHM project undertaken by the Federation of Dental Societies of Greater Montreal under the direction of Dr. Marvin Steinberg and Dr. Jean Robert Vincent. A booth was set up at the Salon de la Jeunesse. Over 16,000 signatures were collected from Quebecers who were asked to take the "Pledge".

Dental Health Month materials were promoted to the profession on a direct mail basis via a number of different vehicles such as the Journal, the February and March issues of the CDA Communiqué and a separate order form for DHM materials. As in previous years, members were sampled with a free copy of the DHM button, decal and poster. In addition, ten copies of the Chatelaine Check-up were mailed to each member..

It appears that more and more members are ordering materials on a direct mail basis rather than through their provincial dental associations.

As has been the practice in previous years, CDA's DHM campaign was launched at a successful Ottawa reception on April 2 to which our friends in government, the dental industry and health care associations were invited.

COUNCIL ON INFORMATION SERVICES

6. Media Relations

CDA's media coverage again peaked during Dental Health Month. Our print media coverage for the period January - May 1987 indicates 1869 clippings in the following areas: policy issues, general interest, DAP/DHM and people/miscellaneous. This compares with a total of 2460 clippings from June 1985 to June 1986.

In addition 20 teleclip reports (broadcast media) were reported for the same January - May 1987 period. This does not include airings of "Bob's Teeth".

7. DHM Poster Contest Winners

CDA once again sponsored a national children's poster contest during Dental Health Month. The winners are:

<u>Name</u>	<u>Age Category</u>	<u>Province</u>
Christa Sable	Grades 5 -7	Manitoba
Michael Yabuta	Grades 4 -6	Ontario
Lloyd Taggart	Kindergarten - Grade 1	Nova Scotia

Each child receives a congratulatory letter from CDA and a cheque for \$175 to be used to purchase a bicycle. Six of the ten provinces participated in the contest. Quebec, Newfoundland, New Brunswick and P.E.I. did not participate this year.

8. Member Communications

CDA members continue to receive information on the DAP through a number of different vehicles such as the Journal and Communiqué. As a result of the mandate of the Publications Committee to restructure the Journal to include issues currently contained in the Communiqué, DAP news will be reformatted to provide greater visibility and identification in the Journal.

COUNCIL ON INFORMATION SERVICES

9. Seminar Series

Council is pleased to note that the first official DAP seminar is scheduled to be held in Winnipeg in late September. Details are currently being worked out between the Manitoba Dental Association and CDA on the format, presentation and financing for this seminar. Following Board approval of this concept in April, the seminar is being planned in order to ensure that CDA does not face any financial difficulties in the administration of this endeavour.

It is anticipated that further bookings will be confirmed by the September Board meeting.

10. Targeted Programming

Two programming efforts are currently under development - a generic senior's program kit, funded by the Canadian Fund for Dental Education, and a children's program funded by corporate sponsorship.

The generic senior's kit will be a model that the dental community and health units can use in developing dental programs for seniors. This project has generated a great deal of interest from communities across Canada and it is anticipated that the kit will be available in the fall. Materials will include fact sheets, A -V, posters and a program guide.

Negotiations are currently underway to sponsor a children's dental program incorporating print and T.V. advertising. The focus of the campaign will be parents of children ages two to eight and emphasis will be on a child's first teeth. The anticipated budget is \$300,000 - \$350,000. Further details will be announced as they are confirmed.

In addition the Toronto Senior's Program, begun last year, will continue in 1987 and added resources will be developed to compliment the 1986 campaign.

11. Corporate Sponsorship/Joint Initiatives

CDA was once again pleased to receive Colgate's support of its Third Dental Health Check-up in the May 1987 issue of Chatelaine. Over 1.1 million copies were printed and distributed during April and May.

Council feels that the Third Check-up follows in the tradition of excellence established by the previous two issues and looks forward to the results of the readership survey being undertaken by Chatelaine on the May 1987 issue.

COUNCIL ON INFORMATION SERVICES

Colgate's support of this project exceeded \$325,000.

In addition Warner-Lambert supported the 1987 DHM campaign by distributing DHM posters, buttons and decals to pharmacies across the country.

Council notes that through the joint initiatives of CDA's Third Party Dental Plans Committee and the Ontario Dental Association, over \$950,000 worth of "Good for Life" public education exposure has been obtained through the distribution of the Consumer's Guide to Dental Care. 430,000 copies of the Guide were produced, of which 5,000 were reserved for shipment to respondents; 14,000 were sent to CDA offices in Ottawa; the remainder were shipped to the provincial dental associations.

As of June 10, 1987, a total of 730 responses have been received from magazine advertisement coupons.

A total of 4,440 have been shipped out from the CDA offices.

Other joint initiatives include CFDE's grant of \$10,000 for the generic senior's kit and a second \$10,000 grant for an as yet to be named project. This is in addition to their \$4,000 support of the 1988 DHM poster.

12. Support Services

Market Research - Health and Welfare Application

CDA was disappointed to learn that its application to Health and Welfare for grant monies to undertake a comprehensive evaluation of the DAP has been refused.

Reviewer's comments have been evaluated and it is anticipated that CDA will resubmit its application in the fall.

13. Health and Welfare

CDA continues to liaise with Health and Welfare concerning its health promotion activities. CDA representatives attended a meeting in May 1987 to discuss development of a dental health promotion document. Discussions were fruitful and objectives set to initiate a process for setting national dental health objectives to the year 2000.

In addition , CDA continues to receive coverage of its DAP activities in the Health and Welfare publication entitled Health Promotion.

14. Budget and Finance

APP. 1

Council provides for the Board's review final 1986 figures, 1987 costs to date and 1988 budget figures. As mentioned in item #2, Council recommends approval of a \$250,000 expenditure in support of 1988 DHM and DAP activities.

15. CDA Distribution of Specialty Section Materials

Council received a request from the Publications Committee to review a request from Dr. Malcolm Miller, Director of the Canadian Academy of Periodontology to distribute CAP brochures on periodontal disease with CDA's mailings to members.

Council feels that it should promote distribution of Good for Life materials and those recommended by Management Committee as deemed to be essential to the profession only. Specialty groups should be encouraged to support the DAP and publish joint ventures under the banner of the Good for Life program. Editorial content should rest with CDA.

Should specialty groups develop their own materials CDA could offer to list their materials in the Journal with the name of an available contact person.

Council notes that it concurs with the feelings of the Publications Committee on this issue.

16. Council Membership

Council notes that both Dr. Terry Koltek and Dr. Rick Howaniec will be leaving the Council after many years of valuable service to the CDA. We thank them for their hard work and efforts on CDA's behalf over the years and in the strong support and direction they provided the Dental Awareness Program particularly in its infancy.

Council wishes them well in their future endeavours.

COUNCIL ON INFORMATION SERVICES

I would like to thank the CDA and the ODA for the confidence they have bestowed on me and for the opportunity to serve on this Council. It has been an extremely rewarding experience. I wish the incoming Council all the best. I have always found CDA staff to be encouraging, co-operative and knowledgeable. It has been a privilege to serve all those enthusiastic in their support of dentistry.

Respectfully submitted,

Dr. Yosh Kamachi, Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Information Services with appreciation.

1988 BUDGET
INFORMATION SERVICES

	<u>1986 Actuals</u>	<u>1987 Actuals</u> (To April 30)	<u>1987 Budget</u>	<u>1988 Budget</u>
<u>Revenue</u>				
DAP/DHM	\$276,720	\$245,228	\$33,000	\$40,000
Publications	87,413	33,376	90,000	100,000
<u>Expenses</u>				
Travel & Accom.	13,830	3,959	12,510	16,020
Per Diems	5,772	936	2,340	2,442
DHM	85,404	74,659	75,000	75,000
DAP Consultants	437,067	7,695	150,000	175,000
DAP Admin.	21,714	1,313	22,500	25,000
Pamphlets/Publications	64,468	12,486	65,000	80,000
News/Communiqué	35,859	27,255	28,000	30,000
Press Clippings	6,574	2,862	3,000	6,000
Film Distribution	3,348	667	2,200	3,000
<u>CFDE Grants in 1988</u>				
DAP	10,000			
DHM	4,000			

INFORMATION SERVICES

1988 BUDGET NOTES

Travel and Accommodation Expenses

3 1-day meetings
6 members (5 Committee & 1 Exec. Liaison)

Travel - 6 x 3 x \$500	\$9,000	
Accom. - 6 x 6 x \$195	<u>7,020</u>	\$16,020

Per Diems

Chairman of Council

3 x \$324	\$972
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Executive Liaison

3 x \$490	<u>\$1,470</u>	\$2,442
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DHM & DAP

A \$250,000 expenditure was recommended by the Council on Information Services in June 1986 for 1988. The division of expenses between DHM and DAP follows CDA's traditional pattern of expenses for the past three years.

DAP Administration

10% of the total DHM/DAP expenses was budgeted for admin costs.

Pamphlets/Publications

An \$80,000 expenditure was budgeted to incorporate our regular pamphlet costs, the inclusion of the Oral-B brochure and Consumer's Guide into our inventory and the developmental costs for pamphlet program revisions.

COUNCIL ON INSURANCE AND INVESTMENT (CDSPI)

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. G. Anthony - Atlantic Provinces
Dr. G.F. Copithorne, British Columbia
Dr. J.M. Dillon, Manitoba
Dr. G. Dubé, CDA
Dr. D. Montminy, Québec
Dr. R.L. Rasmussen, Alberta
Dr. R.R. Schiewe, Ontario
Dr. R.D. Wells, Ontario
Dr. J.N. Wright, CDA

Observers at the CDSPI Board are:

Dr. D.W. Allen, Prince Edward Island
Dr. C.R. Hill, Saskatchewan
Dr. R.A. Turcotte, New Brunswick
Dr. G.S. Zwicker, Nova Scotia

Members of the CDSPI Management Committee are:

Dr. J.E. Durran, President, Burlington
Dr. R.L. Moran, Treasurer, Toronto
Dr. M.D. Charendoff, Secretary, Toronto

This report includes all items of business which require Board action and all information which has become available since the April 3 and 4, 1987 Interim Meeting.

The CDSPI Board met on March 6, 1987 and June 5 and 6, 1987.

ITEMS REQUIRING BOARD ACTION

1. General Insurance

The CDSPI Executive Vice-President and our brokers met with Guardian representatives many times during the early months of 1987. The results of those meetings are the following Motions:

RESOLVED:

- 87.116 THAT the office contents policy for 1988 be renewed with the Guardian Insurance Company with no premium increase.

ADOPTED

RESOLVED:

- 87.117 THAT a minimum coverage level of \$50,000 be established for 1988 in the practice interruption policy with a corresponding premium reduction of 10%; such renewal to be with the Guardian Insurance Company.

ADOPTED

RESOLVED:

- 87.118 THAT the comprehensive general liability policy for 1988 with the Guardian Insurance Company be renewed at the premium rates as quoted for the three levels of coverage.

ADOPTED

RESOLVED:

- 87.119 THAT the Guardian Insurance Company quotation for 1988 malpractice coverage be accepted for both rates and the offering of a new higher limit of \$3,000,000; and no change in the rates for auxiliaries for 1988 be accepted.

ADOPTED

The following rate schedule reflects the rates approved in the above Motions:

RATE SCHEDULE

1988 General Insurance
Renewal Comparisons

	<u>Current Rates</u>		<u>Proposed Rates</u>	
	<u>1987</u>		<u>1988</u>	
	<u>Guardian</u>		<u>Guardian</u>	
	<u>Net</u>	<u>Gross</u>	<u>Net</u>	<u>Gross</u>
<u>Office Contents</u>	per provincial schedules		no change	
<u>Practice Interruption</u>	2.05	2.36	1.85	2.12

CGL

(per \$1,000,000)	69.00	79.00	79.00	91.00
(per \$2,000,000)	150.00	173.00	150.00	173.00
(per \$3,000,000)	188.00	216.00	188.00	216.00

Malpractice

(per \$1,000,000)	484.00	557.00	542.00	623.00
(per \$2,000,000)	552.00	635.00	618.00	711.00
(per \$3,000,000)	not available		665.00	765.00

Auxiliaries

(per \$500,000)	12.03	13.84	12.03	13.84
(per \$1,000,000)	16.87	19.40	16.87	19.40

Note: The above recommendations are valid unless there is a change in their (Guardian) reinsurance treaty wordings or terms.

2. Unit Split of the CDA RSP Common Stock Fund

There are three main reasons for this suggestion:

1. Now that we have auxiliary staff as well as dentists and their spouses eligible for the RSP, more individuals than ever before are contributing on a monthly basis. Some individuals are putting in \$100 monthly, or less, and at a price of more than \$140, they are purchasing less than one whole unit with each contribution. From a psychological viewpoint, it does not appear as if they are getting very much for their money.
2. We have had a bull market now for over 4 1/2 years, and sooner or later there has to be a major correction. A unit price of \$150, with a market correction of perhaps 20%, would result in a drop in value of \$30 in the unit price to \$120. Again, psychologically speaking, this could create some fear and panic in that the Fund is going out of existence. If we were to split the Fund 10 for 1, at \$150, the unit price would then be \$15 and a 20% drop would take the unit price to \$12. The drop does not seem as dramatic. It would probably result in less fear and panic in the unsophisticated investors.
3. We have had a number of dentists question why our unit price is so high in the Common Stock fund, when the majority of Funds' unit values were in the \$15 to \$20 range. They accepted our explanation of a 30-year old Fund that has grown to that extent, but a unit split would put us more in the general vicinity of unit prices overall.

We further discussed the concept with Imperial Life and Impco Investment Management Limited. They indicated that the main reason companies split the unit values is to encourage broader ownership, and since this "is also your prime reason for splitting, your request appears reasonable".

The Council on Insurance and Investment of the CDA recommends to the CDA Board of Governors:

RESOLVED:

- 87.120 THAT the unit value of the common stock fund of the CDA RSP be split on a ten for one basis.**

ADOPTED

Note: The split would take place in late September or early October - subject to advice from legal and Impco.

3. CDIP Eligibility - Auxiliaries

Having studied the transcript of the April 1987 CDA Board Meeting, and having reconsidered the entire matter of CDIP eligibility as requested by the CDA, the Council on Insurance and Investment has developed the following guidelines for auxiliaries:

1. Those that are currently in the Life, AD&D and LTD programs of the Canadian Dentists' Insurance Program should remain in the Program as long as they pay their premium, but cannot increase their current coverage.
2. Any new applicants will only be able to join the Staff Plan, and only on the basis that they work for an eligible employer and work for a minimum of 20 hours per week.
3. The employee of any eligible dentist can participate in the CDIP Malpractice Plan.
4. The employee, in order to claim under either the Staff Plan or current CDIP coverage must have dental income. Dental income is defined as income earned by the individual in any capacity within the employer's office related to the practice of dentistry.

The Council on Insurance and Investment therefore recommends to the CDA Board of Governors:

RESOLVED:

- 87.121 THAT the CDA adopt the guidelines for CDIP Eligibility - Auxiliaries effective January 1, 1988 for all non-licensed dentist applicants to the Canadian Dentists' Insurance Program.**

ADOPTED

4. Non-Registered Investment Funds - MD Management Proposal

Appendix A

CDSPI received a letter from the CDA which requested that we review a proposal from the CMA (Canadian Medical Association) concerning participation in a new Equity Mutual Fund which was to be provided through MD Management (a subsidiary of the CMA). This Fund was also to be offered to other professions.

A meeting was held on September 15, 1986 involving the CDSPI Executive Vice-President, the CDSPI Director of Retirement Services and representatives of MD Management.

The CDSPI Management Committee reviewed a report of that meeting and requested additional information before a report could be presented to the CDSPI Board and the CDA Executive Council. Additional information was requested on the following topics:

1. Membership Services - Is it a priority item for the CDA and CDSPI to become involved in a non-registered investment fund?
2. Directors' and Officers' Liability Insurance - Is more coverage required for the CDA and CDSPI due to the added potential exposure, and is it available?
3. Evaluation of other MD Management Fund performances over the past five years.
4. The requirements for promotion and recordkeeping which would preserve the perception that this is a CDA-provided membership service and the costs associated with those requirements.
5. The legal opinion regarding CDSPI and the CDA operating in such a way that our membership is protected and the operation of the Fund from the standpoint of the dental profession is adequately supervised. This would probably require a seat on the MD Fund Management Board.
6. Dangers associated with the endorsement of such a proposal and Fund without complete control.

An exchange of letters and information with our lawyers made consideration of the other topics listed above unnecessary, and I will quote from those letters in order to demonstrate the reason for the recommendation from the Council on Insurance and Investment to the CDA.

Campbell, Godfrey & Lewtas discussed the issues involved with a Mr. Michael Emory of Aird & Burlis, who is acting for MD Management in connection with its proposed Fund. He advised our lawyer that, "His firm's discussion with MD Management relating to the proposal are at a very preliminary stage, and that he assumed MD Management is testing the waters to determine how much interest there is likely to be among professional associations in sponsoring a Fund of the type proposed".

In response, our lawyers stated, "From the point of view of the CDA and CDSPI, we have two concerns about the proposal. If the Fund is marketed to CDA members in the manner described, CDSPI will be trading in securities. It is, of course, not entitled to engage in trading without being registered under the Securities Act of the various provinces - MD Management is a fully registered securities dealer".

The lawyers go on to state that, "In order to achieve the supervision of the Fund as required, that a director would have to be appointed to the MD Management Board, and that director would have the same significant exposure which all directors of issuers distributing securities to the public now have under the various Securities Acts. The director appointed by the CDA or CDSPI would have a high level of involvement in the supervision of the activities of the Fund".

Finally, an inter-office memo between two members of our legal firm, dated November 26, 1986, was reviewed by CDSPI in December, and is attached as Appendix A for your information. The final paragraph on page 3 states the two main reasons for the Council's recommendation, which are summarized as follows:

1. CDA and CDSPI do not wish to become securities dealers because of the threat to their non-profit status.
2. Forming an entity similar to MD Management is a large undertaking which the CDA and CDSPI would probably not wish to do for the sake of making a non-registered fund available to its members.

Therefore, the Council on Insurance and Investment recommends to the CDA Board of Governors:

RESOLVED:

87.122 THAT the CDA not co-sponsor a non-registered fund to the dental profession through MD Management.

ADOPTED

CDSPI will, however, continue to investigate ways in which a Non-Registered Fund can possibly be offered to the profession eliminating the above concerns, and will be reporting to the CDSPI Board on the results of our investigation at a future date.

5. Malpractice Extension and Surrender of Licence

In 1986, the Guardian Insurance Company put into effect new rules relating to the five-year extension clause in the Malpractice policy. Currently, when an individual retires or becomes permanently disabled, he/she is given, free of charge, an extension of Malpractice coverage for five years. This covers that individual for any potential claims arising from work done while actually practising.

Here is how it works - under the current malpractice policy, a person is deemed eligible for coverage under Clause 14 (the extension clause) if they declare in writing to the insurer that they are no longer practising the profession of dentistry as of the specified date, AND have given up or surrendered to the licensing body their license to practice. These are the exact words of the policy. These words are at the specific request of the insurer and the reinsurers as they feel that, even if you are retired or disabled, the occasion might arise that you would do a little dentistry and you would immediately become a risk to the Plan.

If you have a licence or keep your licence, and wish Malpractice Insurance under the above noted circumstances, you must pay the full premium. The following is the problem:

Our normal procedure that occurs is that an individual informs us of his/her retirement, and we advise them that they must go to their licensing body and obtain written confirmation that they have "turned in their licence". They would then be eligible, as of that date, for the five year extension and the premium rebate, if such should apply.

Unfortunately, some licensing bodies are unable to confirm to us the date of surrender of licence, which would confirm that the practice of dentistry had ceased. The main reason for this situation is that some licensing bodies do not become aware of the retirement or cessation of practice until the dentist simply fails to renew his/her licence. It also appears that, as far as some licensing bodies are concerned, a dentist is still eligible to practice until such time as he/she fails to renew. This results in our participants paying more Malpractice premium than would otherwise be required.

Although the foregoing is not accompanied by a Motion, it is included in this section of our report in the hope that a recommendation could be forthcoming from the CDA which would request the licensing bodies to examine their procedures for accepting the surrender of licence with a view to not only allow participants to claim a refund of Malpractice premiums, but also it might be seen to be fair to refund a portion of the licence fee.

Executive Council Comment: It is the duty of the CDA to identify concerns in this area, and the responsibility of the licensing bodies to act appropriately.

6. Management of Life Surplus

CDSPI, acting as the Council on Insurance and Investment for the CDA, presents the following report in an attempt to assist the Executive Council of the CDA in its quest for the solution of the management of the fortunate problem of a distribution of surplus as generated in the Life Program.

I am sure the CDA Executive is aware that CDSPI has been researching possible approaches to the problem since the 1983 experience results become available in mid-1984. At that time there was a dramatic improvement in the experience surplus on an annual basis from \$23,000 in 1982 to \$480,000 in 1983. Attached for your study, and labelled as Appendix B, are:

Appendix B

1. Report entitled "Management of Life Surplus - Report to the CDSPI Board from the Management Committee" pages 1-15, dated May 15, 1987.
2. TPF&C report, dated May 13, 1987, "Alternative Applications of Surplus".
3. TPF&C report entitled, "Life Premium Rate Credit Program 1988", dated May 5, 1987.
4. Page entitled "Exhibit 1 - Tracking of Life Surplus and Exhibit 2 has Life Surplus by Province as at December 31, 1986".
5. Pages entitled, "Exhibit 3", letter from R.H. Apsey, formerly Vice-President of Kench & Associates, subsequently Executive Vice-President of Reed Stenhouse, and latterly Vice-Chairman of Reed Stenhouse and Associates. (Independent consultant letter as requested by CDA)

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6. Pages entitled, "Exhibit 4", letter from R.E. Brown, former Vice-President of Marketing at Imperial Life, now President of Eaton Bay Financial.
 7. Supplementary report to CDSPI Board re Management of Surplus, dated June 4, 1987.
 8. Letter from TPF&C dated June 2, 1987 re 1988 LTD Renewal.
 9. Lawyer's letter re Surplus Distribution, dated May 28, 1987. (Dealing with questions asked by CDA Management Committee as at May 9, 1987 meeting).

Please refer to Appendix B - 1. This report was prepared by the Management Committee of CDSPI as a result of the decisions which were taken by the CDSPI Board at its March 1987 Meeting.

A number of options were presented for consideration of the CDSPI Board, and some of these options had already been developed in earlier sessions. For example, the Bonus Life Program was developed in 1984 and early 1985 and was presented in June 1985. The reasons for further study and non-acceptance are found on page 5 of the above report.

Please remember that the year 1984 Experience Statement showed that the combined LTD and Office Overhead rate stabilization reserve was \$1.5 million. In order to understand what happened next, you should be aware that the 1986 combined rate stabilization reserve stands at \$.2 million. The change in the LTD experience was noted in the 1985 experience statements and, at the time of the Annual Meeting of the CDA in Halifax in 1986, there was some discussion regarding the possible cross-subsidization of the LTD by the use of Life Surplus. This idea, although not new, triggered a need for legal opinions which resulted in the presumption that the CDA Executive must distribute surplus.

Pursuing the concept that a combined package of enhancements and possible cross-subsidy of LTD would result in an equitable distribution of surplus, the Management Committee continued negotiations with Imperial Life. In order to review these negotiations, please read the material contained on pages 5 through 9 of Appendix B-1.

Then, please move to page 16 of Appendix B-2 for TPF&C's comments regarding Imperial Life's proposal and the outline of the counter-proposal made by CDSPI. The centre of page 16 notes the unsatisfactory status of the proposal.

We would now draw your attention to Appendix B-8, with special note to Appendix A of that letter. Imperial's response to our counter-proposal (Column C), made it clear that we were not able to negotiate a three-year guarantee of LTD rates, but rather a one year 1988 renewal rate for LTD. Please remember that the Life rates are guaranteed for three years, but the LTD are renewed annually.

Consequently, TPF&C were instructed to cease negotiations with Imperial with respect to a Life/LTD/Office Overhead three-year rate guarantee as one means of distributing surplus, and to concentrate on the renewal negotiations for 1988. The results of that negotiation are summarized on page 2 of Appendix B-7 (our June 4th supplementary report to the CDSPI Board), and Column D of the appendix with that report should be noted.

Column D can be misleading as it includes the probabilities of cost associated with the results from 1987. However, the final conclusion is that the LTD rates for 1988 have been negotiated, and the Motion to the CDA will be as contained on page 2 of Appendix B-7.

I will now report, in detail, the results of the CDSPI Board Meeting of June 5 and 6, 1987. Please remember that the Board, which is made up of representatives appointed by every province in Canada, and two representatives from the CDA, received for study, two weeks in advance, all of the material contained in this report except for the June 4, 1987 supplementary report from TPF&C, which was received the night before the meeting.

As Chairman of the Council, I presented that addendum which is attached and referred to above.

What followed was a 5-hour discussion which reflected the concerns of these representatives for the safety and stability of the Plans, the requirements of the CDA Executive, the requirements of equitability which each participant deserves, and the right that each participant has to expect that his/her financial security is being carefully protected by the trustees of these Plans.

The Council on Insurance and Investment finally arrived at the conclusion that the appropriate method to use to arrive at how much money was available for Plan enhancement (that is surplus distribution), was to decide how much should be retained as a reserve in order to guarantee the stability and safety of the Life Plan. (Refer to Appendix B-5 and B-6 for comments made in this area by independent consultant and current insurer).

Having established the level of that reserve, they then felt they were at liberty to recommend distribution of the remainder by various means. The Motions contained at the end of this report reflect those conclusions.

The 5-hour marathon referred to above included full discussion of two alternatives that the Management Committee was not prepared to recommend; that is a cash distribution beyond the recommended premium discount and the Life/LTD/Office Overhead rate guarantee which was deemed to be unsatisfactory from a cost standpoint.

Therefore, the Council on Insurance and Investment is presenting four alternatives for distribution of surplus:

1. The Bonus Life Program
2. Cash Distribution
3. Life/LTD/Office Overhead Rate Guarantee for Three Years
4. Program Enhancements - as detailed in the attached Motion.

The first three alternatives are not recommended for the reasons as contained in this report. The Program enhancements represent an allocation of surplus by the setting aside of dollars to a reserve account which must remain in place in order to guarantee the continuation of the enhancement. There can be no liquidation of that reserve if the enhancement is to remain. The allocation is an ongoing cost, and there is no precedent at this time which would support the withdrawal of that benefit. The premium discount to take effect on the January 1, 1988 invoices is a direct reduction of surplus. It is the Council's belief that the following Motions provide the answers to the requirements as set forth by the CDA Executive; therefore the Council on Insurance and Investment of the CDA recommends to the CDA Board of Governors:

RESOLVED:

- 87.123** THAT a 15% rate increase on CDIP LTD Annual Premiums take effect January 1, 1988.

ADOPTED

RESOLVED:

- 87.124** THAT the LTD program be renewed for a period of one year, with the following special contract considerations:

- The special draw down at the end of 1987 will be computed with reference to the new open claims reserve basis under the LTD. However, an allowance of \$600,000 will be given for the change in the reserve basis that occurred at the end of 1986.

-
- There will be a further contingent draw from surplus at the end of 1988, which will be the lesser of:

- (a) 15% of net 1988 LTD premium; and
- (b) the cumulative deficit under the combined disability account at the end of 1988, based on the new reserve basis.

ADOPTED

RESOLVED:
87.125

THAT a premium discount of 23.8% be applied to life insurance invoices of January 1, 1988 relating to those participants having active life coverage as of October 15, 1987; with such premium discount to be funded from prior years' accumulated investment surplus.

DEFERRED

Note: This motion was deferred until the reserve fund distribution was dealt with.

RESOLVED:
87.126

THAT CDSPI annually report to the CDA the portion of the combined experience and investment surplus to be held in reserve and the portion available for distribution.

ADOPTED

RESOLVED:
87.127

THAT a motion to deal with the contingency reserve of \$3,500,000 be deferred until next Board meeting.

DEFEATED

RESOLVED:
87.128

THAT a contingency reserve of \$3,500,000 be set aside to maintain financial stability in the plans.

ADOPTED

NOTE: Quebec governors instructed by their corporate body to vote against such a motion.

RESOLVED:

87.129 THAT CDSPI earmark \$1,000,000 of the \$3,500,000 contingency reserve for distribution over the years 1989, 1990 and 1991, with the understanding that the CDA Executive Council and the CDA Board of Governors expects the Council on Insurance and Investment to report on and confirm the practicality of this approach in terms of further experience.

ADOPTED

RESOLVED:

87.130 THAT a premium discount of 23.8% be applied to life insurance invoices of January 1, 1988 relating to those participants having active life coverage as of October 15, 1987; with such premium discount to be funded from prior years' accumulated investment surplus.

ADOPTED

RESOLVED:

87.131 THAT a sum be set aside in a special enhancement reserve to fund package improvements as follows:

1. Grad package	\$100,000	ADOPTED
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NOTE: Quebec governors abstained.

RESOLVED:

87.132 THAT a sum be set aside in a special enhancement reserve to fund package improvements as follows:

2. 23.8% distribution	\$660,000	ADOPTED
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NOTE: Quebec governors abstained.

RESOLVED:

87.133 THAT a sum be set aside in a special enhancement reserve to fund package improvements as follows:

3. Elimination of pooling	\$125,000	ADOPTED
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NOTE: Quebec governors abstained.

RESOLVED:

87.134 THAT a sum be set aside in a special enhancement reserve to fund package improvements as follows:

4. Increase of maximum coverage	\$15,000	ADOPTED
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NOTE: Quebec governors abstained.

RESOLVED:

87.135 THAT a sum be set aside in a special enhancement reserve to fund package improvements as follows:

5. Retiree life coverage/ open enrollment	\$1,600,000	DEFEATED
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NOTE: Quebec governors abstained.

RESOLVED:

87.136 THAT the Canadian Dental Association be strongly urged to enter into agreements with each of the co-sponsors of the CDIP Plans in the form of a draft agreement as passed at the March 1987 CDSPI Board Meeting amending the 1987 Participation Agreements.

ADOPTED

NOTE: Quebec governors opposed this motion.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

1. CDA RSP

The Plan Year 1986 saw exceptional growth in Plan assets which stood at \$76,000,000 at the end of the year. There was a 125% dollar increase in total contributions over the previous year - in dollars this represents \$15,000,000.

This is the third consecutive year that contributions have doubled the contribution level of the previous year. We do not anticipate that this rate of growth will continue.

The most significant increase figure is in the number of Plan participants - this has grown from 1,797 in April 1986 to 2,699 in April 1987.

The CDA RSP growth is documented as Appendix C, and is reported as at April 30th. Appendix C

2. Retirement Counselling

The seminars that have been held in 1987 have shown a very satisfactory increase in the number of participants. Victoria and Vancouver had participation levels three times higher than 1986 and Edmonton had more than double the number of registrants that attended Calgary the year before. It appears that word of mouth advertising is selling the value of

this service. The demand for places at the Toronto seminar was so heavy that a second date had to be arranged for May 9, 1987 in addition to the regular May 8, 1987 date. There are still seminars scheduled in 1987 for Ottawa (September 11), London (September 18), Montréal (October 2) and Halifax (October 23).

3. 1986 Plan Statistics

At the June CDSPI Board Meeting, the 1986 National Experience and Statistics Report (our Annual Plan Statistics Report) was presented.

Each Co-Sponsor will be receiving their individual provincial results from our office.

Attached as Appendix D are some statistic figures on a national basis for your information.

Appendix D

4. Market Research Project

CDSPI is conducting a Market Research Project which should provide us with a number of answers relating to our insurance participants, our RSP participants, our current services, and our growth potential. It should also provide us with information on the future requirements of dentists which could be provided by organizations such as the CDA and CDSPI.

The survey will be mailed in early June, and a full report will be made to our Board in September, with a follow-up at the CDA Interim Meeting.

5. Dental Office Management System (DOMS)

On Saturday, June 6, 1987 the CDSPI Board received a one hour presentation of the CDSPI computer package. This is the same presentation that any one person or group will receive before they start to take an in-depth look at the pros and cons of computerization. The project is on schedule, and the pilot offices are using the hardware and software that has been installed at their sites.

Our staff is in place, the system is being tested and debugged, the education for the pilots has been presented, and the CDA Annual Meeting will hear an update that says we have entered the marketplace.

Respectfully submitted,

John E. Durran, D.D.S., Chairman
Council on Insurance and Investment
President - CDSPI

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Insurance and Investment with appreciation.

CAMPBELL GODFREY & LEWTAS**MEMORANDUM**

TO: Beth Moore

FROM: Tracey Kernahan

DATE: November 26, 1986

FILE: CANADIAN DENTAL SERVICE PLANS INC. ("CDSPI")
Re: MD Management
030328-033

MD Management Inc., a fully registered securities dealer, intends to set up a non-registered fund (the "Fund") somewhat similar to a registered mutual fund in March of 1987. It has requested that various professional organizations essentially co-sponsor the Fund by promoting it to their members. The main administration of the Fund, together with the preparation of financial statements and all information reports, would be performed by MD Management. The promotional material would also be developed by MD Management but would contain the name and logo of the Canadian Dental Association ("CDA") or CDSPI on the cover. CDA or CDSPI would receive applications and deposits from subscribers and would forward such applications together with one cheque for all deposits on a weekly basis to MD Management. CDA or CDSPI would distribute monthly information reports and financial statements to its subscribers. In addition, CDA or CDSPI would request that a member of its management committee be appointed to the board of directors of the Fund.

You had asked me to review whether this activity would constitute "trading" in the units of the Fund and to make informal inquiries of the Registration Branch of the Ontario Securities Commission to see if such activity would require registration or whether there were forms of limited registration available for such activities.

Section 24 of the Securities Act (Ontario) (the "Act") prohibits a person or company from trading in a security unless registration has been made in accordance with the Act. The definition of trading is inclusive and includes "any sale or disposition of the security for valuable consideration..." and "any act, advertisement, solicitation, conduct or negotiation directly or indirectly in furtherance of any of the foregoing". MD Management will be selling the units of the Fund. However, the actions of CDA or CDSPI in soliciting and advertising the Fund appear to fall within the catch-all clause of the definition of trading. Trading without registration may subject the unregistered party to prosecution under the Act. The activities of CDA and CDSPI as described in their letters would constitute trading. Although the registration requirement is not restricted to trading to the public, I believe the Commission would be more receptive if the activities of CDA and CDSPI did not involve direct solicitation of members.

I have spoken with Ken Trider, Assistant Deputy Director of the Registration Branch of the Ontario Securities

Commission. Based on a brief description of the facts on an anonymous basis, it was his preliminary reaction that CDA or CDSPI would have two options with respect to making the mutual fund available to their members:

1. to establish themselves as a mutual fund adviser or securities dealer (he cited MD Management as an example); or
2. employ a securities dealer to carry on the solicitation and trading function. This would reduce the profile of CDA or CDSPI with its members which is not in accordance with their wishes.

As CDA and CDSPI do not want to establish themselves as securities dealers, due to their status as non-profit corporations, it might be possible, subject to the capital requirements of the Act, to form an entity similar to MD Management for dental funds and essentially run separate funds or co-manage the funds with MD Management. This, however, is a much larger undertaking and one which may not wish to be entered into by CDA or CDSPI. Finally, there is no form of limited registration which would be available to CDA or CDSPI to carry on their proposed activities.

T.K.

:hk

TO: The CDSPI Board of Directors
FROM: The Management Committee
DATE: May 15, 1987
RE: Management of Life Surplus

At the March Board of Directors' Meeting, the following Motion was passed by this Board:

"THAT THE MANAGEMENT COMMITTEE BE DIRECTED TO NEGOTIATE WITH IMPERIAL LIFE THE OPTIONS OUTLINED IN THE TPF&C REPORTS SUBMITTED TO THE MARCH 1987 BOARD MEETING AND BRING BACK RECOMMENDATIONS TO THE CDSPI BOARD MEETING IN JUNE 1987".

The purpose of the review of these options is as a result of direction from the CDA Executive Council Meeting of February 13 - 15, 1987. The essence of the direction at that time was that "CDSPI and the actuaries should outline at least three different options to look after these concerns and should indicate for each of these options the administrative, physical and marketing advantages and disadvantages, and how each option complies with the above".

The "above" that is referred to is the criteria that the options must respect. These are:

- a) Surplus funds must benefit the dentists who contributed to the funds (equitability).
- b) The benefits should be received pro rata.
- c) The solution must be accomplished within a reasonable period of time.

It is with this in mind that the Management Committee prepares this report for the consideration of the Board of Directors.

The Management Committee has reviewed a number of options for the Board's consideration, in order to comply with the direction from the Executive Council.

We feel these options should be addressed under the following headings:

- a) Bonus Life Program
- b) Package Improvement
- c) Cash Distribution

Areas of equitability and independent consultant opinion have also been addressed.

* * * *

Bonus Life Program

At the June 14, 1985 Board of Directors' Meeting, TPF&C made a presentation. The topic of this presentation included an in-depth review of the area of distribution of surplus. Following the presentation, the Board discussed a concept called "Bonus Life Program".

We quote from the Minutes the result of that discussion:

"The Bonus Life Program, as set out in TPF&C's report, was discussed in considerable detail. It was agreed that there must be a distribution to the participants of a prudent portion of the surplus, with such decision hinging upon the preservation of the safety and stability of the plan, but it was felt that this may not be the most equitable way of achieving this objective. It was felt that CDSPI should investigate other options such as a premium holiday for one year, a cash rebate, or a percentage of coverage increase, all based on the premium paid and the number of years participation in the plan.

The following points were to be taken into consideration when investigating these options:

- 1) Must be equitable to all participants.
- 2) Create an impact on the participants which is favourable to CDSPI.
- 3) Has simple administration requirements.
- 4) All tax implications are favourable.
- 5) Has no effect on the CDA or CDSPI non-profit status".

There are a number of members sitting on the current Board who did not have an opportunity in 1985 to view the Bonus Life Program as an option. As one can see from reviewing the above, there was never a Motion passed relating to the Bonus Life Program. Consequently, we provide for you now a brief outline of the original presentation for your information.

* * * *

The basic concept of a Bonus Life Program is as follows:

- 1) Credits will be given for length of participation and volume of coverage.
- 2) This would be a bonus form of insurance granted at age 65.
- 3) Once granted, it would be guaranteed to continue.

- 4) It would be term insurance.
- 5) There would be no vesting prior to age 65.
- 6) There would be no cash values.
- 7) This would be a feasible allocation of Life surplus.

The proposed Bonus Program details would be as follows:

- 1) One must have participated in the plan for a minimum of ten years at age 65.
- 2) A participant would be given ten credits per year of participation.
- 3) There would be one credit per year per \$10,000 of insurance.
- 4) Bonus insurance would be \$10 multiplied by the number of credits at age 65.
- 5) Any reductions after age 60 would retain credit.
- 6) Premiums would be paid from surplus.
- 7) Program would be guaranteed for persons now age 60 and over.
- 8) There would be a guaranteed review of the Bonus Life Program every three years.

As an example of the above formula, take the following situation:

Dr. John Doe, at age 30, purchases \$100,000 of life insurance, and at age 40 purchases \$50,000 of life insurance. His participant credit would be 10 credits multiplied by 35 (years in the plan), which equals 350 participation credits.

His insurance credits would be 10 credits multiplied by 35 years participation from age 30, which equals 350 credits with the 10 credits relating to one credit per \$10,000 of insurance for the \$100,000 level of coverage. There would then be an additional five credits for the \$50,000 of insurance purchased (one credit per \$10,000) multiplied by 25 years (age 40 - 65), which equals 125 credits. His total insurance credits would then be 475.

Dr. Doe's total bonus credits would be the 475 insurance credits plus the 350 participation credits for a total of 825 credits.

The bonus insurance would be \$8,250, calculated by multiplying the 825 credits by \$10 per credit.

The Bonus Program would have a financial affect:

<u>VALUED AT</u>	<u>PRESENT VALUE OF FUTURE LIABILITIES</u>
9%	\$2.6 million
7%	\$4.5 million
5%	\$8.3 million

The choice of the interest rate depends upon the expected interest earnings on surplus, the emergence of new surplus, and the surplus applied for rate subsidization which at the time of the report was \$450,000 per year.

The emergence of new surplus is very important, but it is unknown. Thus there can only be a limited guarantee for program continuation. Age 60 and over has a commitment of approximately \$600,000 (at 5%); age 55 and over has a commitment of approximately \$1.1 million (at 5%).

If we project the overall financial effect of the Bonus Program, the following table would be produced:

<u>YEAR</u>	<u>PROJECTED TERM PREMIUM</u>
1986	\$ 4,000
1987	\$ 5,000
1988	\$ 12,000
1989	\$ 18,000
1990	\$ 24,000
1995	\$ 67,000
2000	\$148,000
2005	\$280,000
2010	\$555,000

One can see by the above that as the participants grow older, the levels of insurance increase and participation and length of participation increase or remain constant, and the cost of such benefit would escalate.

* * * *

The above is a brief recap of the Bonus Life presentation. As already noted, it was a concept felt unacceptable by the Board in 1985.

The Board found the Bonus Life program unacceptable at the time for the following reasons:

1. It could not be guaranteed.
2. Low benefit for high cost.

3. Necessary to retain surplus in order to be as certain as possible that the Bonus Life program could continue.
4. Carrier was taking no risk, and participants would not find an added \$8,000 - \$10,000 coverage as a big advantage.
5. It would take too long for a participant to gain any benefit.

Package Improvements

As noted at the beginning of this report, a Motion was passed at the March Board Meeting relating to negotiations with Imperial Life and various options contained in the TPF&C report submitted to the Board at that meeting. The Package Improvements section of this report relates to that negotiation.

Accompanying this report is a report from TPF&C dated May 13, 1987, and entitled "Alternative Applications of Surplus". The report reviews the previous report submitted to the Board in March, and comments on the status of each of the options contained in that report after having discussed the underwriting considerations and/or financial impact of each application with Imperial where applicable, or after further discussing the various alternatives with the Management Committee.

We propose at this time to review each of the options contained in this report and provide our comments on each.

OPTION #1 - GROUP LIFE AND LTD PACKAGES

The Management Committee concurs with TPF&C's recommendation regarding this option and are recommending that this option not be pursued.

OPTION #2 - OPEN ENROLLMENT

The Management Committee feels that this option has substantial merit. As outlined in the report, our initial feeling concerning this option was that the enrollment should be increased to \$20,000. The TPF&C recommendation, as outlined on page 5, as to the exact terms of the open enrollment we feel are appropriate.

OPTION #3 - PROMOTION OF CONVERSION OPTION

The conversion option is something that participants currently pay for in their premium. It is something, however, that has not been promoted to the participants at the time when coverage is cut back, and we therefore feel that this is something which should now commence.

As noted at the bottom of page 7 of the TPF&C report, an alternative is available under this option. For the reasons stated, however, it has not been pursued with Imperial and although we feel the option might warrant discussion at some future time, we feel there is no point in bringing this conversion matter to the table with Imperial at this time, as the results could be costly. We feel, however, that we should promote the conversion option, wait until Imperial wishes to discuss conversion with us at some future time, and then look at possible special rates or extending the reduction dates by five years.

In the meantime, our recommendation is that the conversion option be promoted.

OPTION #4 - ELIMINATION OF POOLING

Taking all of the previously researched data into account in connection with this item, the Management Committee feels that there should be an elimination of the pooling limit and that the plan should take the financial risk accordingly.

OPTION #5 - INCREASE OF LIFE MAXIMUM

After reviewing the comments of TPF&C in their previous reports on this subject, the Management Committee recommends that the life maximum be increased to \$750,000.

OPTION #6 - TEMPORARY BONUS LIFE COVERAGE

The Management Committee discussed the effect of this type of additional basic life in detail. It was the feeling of the Management Committee that this option not be considered for two reasons. The first reason was that it has not been a policy under the plan to have anything on a temporary basis, and this feature definitely is proposed to be temporary. The second reason is that it is very similar to the open enrollment option, which we feel is more beneficial.

The Management Committee therefore feels that this option should not be pursued.

OPTION #7 - FREE RETIREE LIFE COVERAGE

Of all of the options under this section of the report, the Management Committee feels that this is the best.

It allows a paid-up benefit to be given to those who have been in the plan the longest, at the oldest age, and will give them the opportunity of feeling they have achieved something during their term of paying premiums, other than just buying ordinary group term insurance.

The Management Committee therefore strongly recommends that this option be a "yes".

OPTION #8 - PREMIUM CREDITS - CURRENT SURPLUS

This option is neither a "yes" or a "no" by choice. Based on the current formula and Schedule A attached to TPF&C's report, there are no surplus funds available from the 1986 surplus to activate a premium discount for the 1988 billing. Therefore, this option, as it now stands, must be a "no".

The Management Committee will make further comment on this later in this report.

OPTION #9 - GUARANTEED LIFE RATES

In the Management Committee's discussion of Option #9, we have looked at it as being an unnecessary option if Option #10 is put in place.

Since the Management Committee has taken the position of feeling that Option #10 is of more benefit to the participants in CDIP, we feel that Option #9, as a singular one, should not be pursued.

In reality, the rates are currently guaranteed for three years (two years remain in that guarantee) and the favourable experience in the Life plan to date has not warranted any increases. The reverse has been true, and that is the rates have decreased.

OPTION #10 - LIFE/LTD/OFFICE OVERHEAD RATE GUARANTEES

This option has been a major platform of the Management Committee in connection with this entire proposal.

It is a confirmed fact that the LTD package requires a rate increase. The Management Committee concur with this fact, and the statements made in TPF&C's report confirm that a rate increase of some percentage should be effective January 1, 1988.

The Management Committee cannot, however, concur with the concept that on one hand a percentage increase (be it 15% or 30%) is applied to participants in the LTD plan, which results in premium payment with after-tax dollars, and on the other hand there are feelings there should be cash distribution back to participants to reduce Life surplus, with such cash distribution being taxable.

Such a transferring of funds from one pocket to another, with the Tax Department in the middle, does not seem to be a good business recommendation. It has therefore been the strong feeling of the Management Committee that Option #10 of rate guarantees, with a reasonable rate increase for LTD, provides the greatest overall stability and benefit to the participants.

It is with this in mind that the Management Committee reviewed Imperial Life's initial proposal as presented on pages 13 through 16, of the TPF&C report. In discussing the Imperial Life proposal with TPF&C we concurred that the proposal and the costs involved were unsatisfactory.

We were able to confirm the unsatisfactory status of the cost of this proposal by instructing TPF&C to "quietly" discuss this form of option with another major insurer in Toronto. The result of that discussion indicated that the price being asked was too high.

As a result of this information, further discussions clearly indicated that the CDIP programs at Imperial Life form a relatively large percentage of the group operations business.

If that "book of business" developed substantial losses, it would present a substantial overall loss to the entire group operation division - something that would not be acceptable from a corporate profit standpoint at Imperial.

It is therefore the feeling that Imperial looks at charging the price for such a package guarantee in order to protect this overall group operations bottom line, and virtually take very little risk.

To another major insurer, who is larger than Imperial Life, the size of our program would represent a very small portion of the overall group business, and therefore they are able to take more risk and spread any dollar losses over a greater dollar base.

It is with this information in mind that the proposal as outlined on the bottom of page 16 and the top of page 17 of the TPF&C report was presented to Imperial Life.

As the TPF&C report indicated, Imperial Life presented their reply at a meeting with the Management Committee on May 20, 1987. The initial feeling concerning their reply is quite positive.

As at the time of finalizing this report for the Board, one or two small areas are being researched and reviewed with TPF&C and Imperial. A final comment will be presented at the Board Meeting.

* * * *

Summary and Conclusions Under Package Improvements

When one reviews page 19 of the accompanying TPF&C report, one can see the estimated draw from surplus regarding options that have a cost attached to them.

If one takes the options which the Management Committee feels should form this Package Improvement section, one obtains the following one-time draw, or present value, of annual draw total.

Option # 2 - Open Enrollment -	\$1,350,000
Option # 3 - Promotion of Conversion -	250,000
Option # 4 - Elimination of Pooling -	125,000
Option # 5 - Increase of Life Maximum -	15,000
Option # 7 - Free Retiree Life Coverage -	1,600,000
Option #10 - Guaranteed Rates for Life/LTD/Office Overhead -	<u>1,500,000</u>
TOTAL	\$4,840,000

One must then add the Graduate coverage cost, which is an ongoing, recurring item from surplus, shown on page 19 of the TPF&C report as \$100,000.

This would be a total of surplus allocation under the Package Improvement, including Graduate coverage, of \$4,940,000.

The total of Life surplus at December 31, 1986 is \$5,889,739, including the \$1,000,000 special contingency reserve.

These improvements, therefore, can be sufficiently funded out of the current surplus as noted.

* * * *

The above is a recap of section 2 of the options available, which we have called Package Improvements. The third option will now be addressed.

Cash Distribution

Before discussing the area of Cash Distribution, we attach to this report two exhibits for your reference. These are found in the report following the TPF&C report of May 13, 1987.

Exhibit 1 is a tracking of CDIP Life surplus from January 1, 1978 to December 31, 1986. This tracking has been broken down between experience surplus and investment surplus. To define these two areas:

Experience surplus is the dollars left over (or lack of them and therefore a deficit) from the premium dollars paid less claims and expenses.

Investment surplus is exclusively the surplus where interest revenue is placed. This interest revenue is earned on the cash flow through, but is also built up substantially from the interest earned from the reserves maintained by the insurance company. Prior to January 1, 1978, the Canadian Dentists' Insurance Program was receiving none of the interest credits. Negotiations, however, set up favourable investment formulas which gave the interest in certain areas to the plan and, obviously, substantially reduced the profit of the insurance company.

It is these figures that are important to be noted when we refer to the statement that the majority of the surplus has been produced by good management of the plans, good negotiations for interest formulas, and high interest rates during certain portions of this time period.

You will note that in the years 1981, 1985 and 1986 there were losses in relation to the experience of the program. In other words, there was insufficient premium to cover the claims and expenses of that year's activities.

The total of those three years' deficits amounted to \$1,009,640. This in itself is good substantiation for the maintenance of a \$1,000,000 minimum contingency reserve to buffer such short term fluctuations in experience.

The question can also be asked, "In 1981, when the experience was in a deficit position of almost \$500,000, what action might have been taken by the insurer in the area of possible rate increase had there not been \$2,000,000 of surplus available to buffer the shock waves".

You will note from Exhibit 1 that the current \$5,889,739 of Life surplus has 70.1% pertaining to investment surplus and only 12.9% relating to experience. The existence of this surplus, therefore, is not because of the accumulation of overpayment of premium by participants.

Exhibit 2 of this report shows a breakdown of the Life surplus at December 3, 1986, by province, in comparison to 1985, with such breakdown based on experience versus premium paid since 1978.

When one considers cash distribution, and one looks at the surplus breakdown by province, should one not ask participants in Saskatchewan and Nova Scotia to pay more?

On August 29, 1985, TPF&C produced a report entitled, "Distribution of Life Surplus". This report was presented to the Board of Directors at the September 1985 Board Meeting. It was this report which introduced the formula for distribution of future surplus, which was used in 1986 to distribute 1985 surplus as a premium discount effective January 1, 1987.

The purpose of that formula was that surplus could be maintained at existing levels, but any future increases in surplus would be returned to the membership when, and if, they arose.

Contained in that report was a section regarding tax and legal implications. At this time we quote from that report:

"We obtained written opinions from two legal firms with respect to the tax and legal factors influencing the choice of surplus distribution methods.

In brief, the tax and legal implications involved in the choice of method are not entirely clear. It does appear however, that the risk of creating taxable income is greatest if a cash rebate method is used, as opposed to the granting of premium credits or additional plan benefits.

Both legal firms conclude - and we (TPF&C) concur - that the risk of creating taxable income is not great if the CDA were to decide to use surplus funds to grant premium credits or additional coverage.

It appears that the non-tax status of the CDA (or CDSPI) would be jeopardized if it is decided that the CDA has "beneficial ownership" of the surplus funds. One of the legal opinions advises that a direct cash payment "not... be made to the members as this appears to be more closely to be a distribution of tax exempt income and would bring the matter to the attention of Revenue Canada".

If the participants are deemed to have "beneficial membership" of the funds, they conclude that the CDA's tax status would not be jeopardized, but a direct cash rebate would likely trigger taxable income to the participants to the extent that the rebate is in part a distribution of accumulated investment income.

Consequently, we recommend that the cash rebate method not be utilized and that distributions be made in the form of premium credits or insurance additions (benefits)."

Based on the summary of facts outlined in this report under this section, the Management Committee strongly feels that cash distribution cannot be an option to be considered under the management of Life surplus.

Although we do not concur with cash distribution, we do concur with the philosophy set out under the current premium discount formula, which was approved by the CDA in 1985 and referred to above.

You will note from the Schedule A attached to the TPF&C May 13, 1987 report the use of this formula to indicate that there is no new surplus available in 1986 (future surplus) for the application of this formula to permit a premium discount effective January 1, 1988. This is due to the fact that experience in 1986 did not produce sufficient surplus to warrant the application of the formula.

The application of the formula relating to 1985 surplus produced a premium credit (discount) of 23.8%. This resulted in a \$658,000 distribution of surplus through the premium discount method.

The Management Committee feels that strong consideration can be given to repeating a 23.8% distribution of surplus through the use of the same premium discount January 1, 1988. This percentage and dollar figure could be used again, as there is a sound basis and precedent set under the previous distribution. As well, since the \$450,000 charge for smoker/non-smoker has been eliminated by negotiation it is reasonable that this sum would be re-distributed next year.

The advantages of doing this would be a continuation of the current policy for the benefit of the participants, and the perception that we just did not give them a one-year benefit in 1987 which now has been taken away. It has not been our marketing philosophy to give one something one year and then remove it.

In conjunction with the continuation of benefit concept, the second advantage would be to apply back to current participants in the form of the discount a portion of the "old surplus".

* * * *

Equitability

There has been considerable discussion by the CDSPI Board, by the CDA Executive Council, and written comment regarding "equitable distribution".

There currently appears to be a conflict between the management of the plans and the management of surplus due to the equitability question.

What is equitability?

The plan should be as equitable as possible so long as it is consistent with good plan management. Good plan management takes into account the following: being as risk-free as possible from law suits; maintaining a certain dollar level in surplus to guarantee rate stability; maintaining a dollar level for leverage and muscle in negotiation; and distributing any excess if practical. It also entails careful attention to reserve setting, actuarial audits, and negotiations with the carriers regarding rates and pooling risks.

Equitability?

- °where plans are available to all participants and benefits are available through options they can get at any time;
- °each participant who has died has gotten fair value for their money while still in the plan, as they have collected;
- °surplus is there because we have put it there. It is there because of good management and negotiation;
- °young lives do not usually die or go on claim and, as such, put the dollars in to hold down the older participants' premiums;
- °this is a group plan, not an individual plan. The group looks after itself as an entire group over time. Individuals do not have any contractual right to dividends or profits, but have every right to benefits or have access to the terms of the contract. For example, when we negotiated non-cancellable guaranteed renewable and "own occupation", everyone in the plan got it.

This is what equitability means in our analysis of this question.

From a legal standpoint, equitability of any type of use of surplus must be exhibited as being reasonably equal to all people who participated in the plan.

If one accepts this concept, then we can eliminate those who have died and collected, because they have received the maximum benefit and received the product in full for which they paid in part.

As you are aware, statistical data regarding movement and participation of those insured in the programs has only really been available since administration was brought in-house. Prior to 1982 any individual dropping out of the program was just dropped off the administrative system. Since CDSPI commenced in-house administration, however, that process has changed.

In order to analyze the equitability, an analysis of the years 1982, 1983 and 1984 were done relating to cancellations of an individual's life coverage. The philosophy that was used in order to do this computer search was the elimination of any accounts that were estates, and allowing a 10% factor for administration cancellations due to transferring of coverages from account to account.

The results of this computer analysis, without analyzing any of the individual cases obtained in the analysis, showed that there were 130 individuals that cancelled all of their life insurance in 1982; 337 cancelled all of their life insurance in 1983; and 248 cancelled all of their life insurance in 1984.

When one takes these figures and compares them to the number of participants in the Life plan, as certified in the annual report of Imperial Life for each year, the percentage for 1982 is 1.6%; for 1983 it is 3.9%; and for 1984 it is 2.9%.

The extension is not carried further for 1985 because 1985 actual surplus was distributed back January 1, 1987 through the premium discount formula.

What these figures really mean is that if a plan benefit, or as in 1987 a premium discount formula, was given or applied, those who are current participants at the time of the application represent by far the majority of the participants. As an example, with only a 1.6% dropout in 1982, the majority of the participants were still in the plan in 1983.

If one takes the three years on an average, it means that 2.8% of the total participation dropped out and therefore did not receive a "return of any future use of surplus".

When taking into account the administrative difficulties of going back to track these individuals, and the cost involved, it is not justifiable for the numbers. It is, therefore, our opinion that any use of surplus in any future year for the participants who are in the program that particular year represents an extremely high percentage of those who have always been in the plan and the benefit or discount is being applied equitably.

* * * *

Independent Opinions

One additional instruction from the CDA Executive Council in connection with this project was "it was felt that a written point of view of an independent insurance consultant would be of value on the proposal to retain a major portion of the surplus and reserve for benefit plan stabilization purposes and its impact on rate structure".

We are pleased to comply with this request by attaching to this report a letter from Robert H. Apsey, Insurance Consultant. This letter is attached as Exhibit 3.

Accompanying this report is Exhibit 4, a further document which formed part of this Board's Minutes from the last Meeting from Mr. Bob Brown of Imperial Life.

Both of these exhibits stress the importance of the maintaining of some form of surplus in order to achieve stability and balance in such a group account.

* * * *

Management Committee Conclusions and Recommendations

The Management Committee feels that the goal of the CDA Executive Council Motion has been achieved through this report.

The question of equitability has been addressed and three options have been presented. The comments of an independent consultant and a senior individual from the current insurer have also formed part of this response.

The Management Committee therefore recommends to the CDSPI Board of Directors:

1. "THAT A 15% RATE INCREASE ON LTD ANNUAL PREMIUMS IN THE CANADIAN DENTISTS' INSURANCE PROGRAM TAKE EFFECT JANUARY 1, 1988."
2. "THAT EFFECTIVE JANUARY 1, 1988, THE PACKAGE IMPROVEMENTS OPTION, AS OUTLINED IN THIS REPORT, BE IMPLEMENTED."
3. "THAT A PREMIUM DISCOUNT OF 23.8% BE APPLIED TO LIFE INSURANCE INVOICES OF JANUARY 1, 1988 RELATING TO THOSE HAVING ACTIVE LIFE COVERAGE AS OF OCTOBER 15, 1987; WITH SUCH PREMIUM DISCOUNT TO BE FUNDED FROM PRIOR YEARS' ACCUMULATED INVESTMENT SURPLUS."
4. "THAT THE CANADIAN DENTAL ASSOCIATION BE STRONGLY URGED TO ENTER INTO AGREEMENTS WITH EACH OF THE CO-SPONSORS OF THE CDIP PLANS IN THE FORM OF A DRAFT AGREEMENT AS PASSED AT THE MARCH 1987 CDSPI BOARD MEETING, AMENDING THE 1987 PARTICIPATION AGREEMENTS."

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If the Board accepts these recommendations, they will form part of the Council on Insurance and Investment's report to the CDA Executive Council immediately following the Board Meeting. After consideration by the CDA Executive Council, these recommendations would then be dealt with at the CDA Board of Governors' Meeting in Ottawa in September 1987.

/cd

Attachments

CANADIAN DENTISTS' INSURANCE PLAN

ALTERNATIVE APPLICATIONS OF SURPLUS

Kenneth T. Ransby
Janet I. Zwarick

May 13, 1987

I. INTRODUCTION

In a report dated February, 1987, we outlined a number of alternatives with respect to the application of the approximately \$5 million in surplus which exists under the CDIP Life insurance account. Also included in that report was a summary of the financial considerations involved with each of the alternatives explored.

Following our February report, we discussed a number of underwriting considerations with officers of Imperial Life in order to obtain their approval in principle with respect to some of the alternative surplus applications being considered. We summarized the alternative applications of surplus and provided a more accurate appraisal of the underwriting considerations and/or financial impact of each application in our report dated April 15, 1987.

The Management Committee has reviewed the various alternatives and their cost implications and has considered some further alternatives. The purpose of this report is to summarize all of the various alternatives and their respective costs.

II. ALTERNATIVES FOR CONSIDERATION

1. Group Life & LTD Package

The package would be sold on the basis of a combined, age-related premium rate, to those participants who want both coverages. The package plan would be sold at subsidized premium rates, to the advantage of participants who want both coverages.

Commentary

Although the idea behind this suggestion is very appealing we believe that, in practice, it would encounter problems.

Many participants would want to combine existing coverage merely to take advantage of lower rates. This would result in additional administration costs.

In addition, in order to have some ongoing balance between the combined rates and the separate Life/Disability rate structure, the package should be split into its component coverages and rated with the individual coverages. This would negate the economies which conceivably could be generated under the group approach.

For the reasons outlined in the foregoing paragraphs, we do not feel that the Life/LTD package should be considered for implementation. Consequently, this option was not discussed with Imperial Life.

2. Open Enrollment Period

Minimum amounts of coverage would be underwritten at attractive rates during an open enrollment period.

Commentary

Open enrollment is feasible if the participation is very high (50% or more). If a low percentage (i.e. predominately the uninsurable individuals) purchased the coverage, future claims could be very heavy relative to the additional premium received.

In our February, 1987 report, we suggested that high participation perhaps could be achieved if \$10,000 of insurance were provided to all CDIP members on a free basis for the first year in anticipation that most would continue the coverage in ensuing years. The same amount could be made available on a premium paying basis to CDA members who are not currently participating in CDIP.

Imperial Life initially offered two alternative underwriting approaches:

- a) For CDIP members, if the coverage were not free there would be "positive billing" for the \$10,000 of insurance i.e. the participant would be automatically billed for the insurance and would have to reject the coverage. In the words of the Imperial Life officers, "the use of a positive approach to this type of benefit is quite successful and minimizes the possibilities of anti-selection. We ... prefer to give the applicant the opportunity to reject as opposed to the opportunity to accept. The latter is more negative and invites anti-selection."

Previously uninsured CDA members who became participants in this manner would be included in a separate division with a separate rate stabilization reserve (RSR) equal to 100% of the applicable premium.

- b) The open enrollment period could be extended to all CDA members, subject to the following "short form" underwriting questionnaire:

"Question 1. Have you, within the past 36 months, been treated or tested for, consulted a physician about, or had any indication of any life threatening disease?"

"Question 2. Has an application for insurance on your life ever been declined, rated or modified?"

If the answer is "yes" to either of these questions, Imperial could insist upon further information before approving the coverage. In addition, issuance of the insurance would only be to those under age 65 and actively at work. Normal premium rates would apply.

We had concerns with both of Imperial Life's proposals:

- The greatest need for the open enrollment coverage is among those CDA members who are not CDIP life insurance participants because their insurance applications have been previously declined. "Positive billing" is not practical for non-CDIP participants. Since the proposal is that the coverage would be provided free to CDIP participants in the first year, "positive billing" for those persons would only be feasible in ensuing years.
- The underwriting questionnaire, however short, defeats the purpose of the open enrollment coverage. In addition, CDIP participants might well question why a longer form of questionnaire exists for normal applications.

We therefore asked Imperial Life to reconsider their stance on the open enrollment coverage. Their third proposal involves open enrollment insurance on an optional basis, at regular premium rates, subject to increase of the Life RSR based on participation in this coverage:

<u>Participation of Eligible Applicants</u>	<u>* Rate Stabilization Reserve</u>
50% or more	same
40% - 49%	10% increase
30% - 39%	20% increase
20% - 29%	30% increase
10% - 19%	40% increase
10% or less	50% increase

* Subject to pro-rata adjustment for amounts other than shown.

Clearly, Imperial Life has an underwriting concern with respect to open enrollment coverage, and this concern increases as potential participation diminishes. We share this concern, and recommend that the following steps be taken in order to maximize participation of those in good health:

- We continue to recommend that the "open enrolment" insurance be provided on a free basis for current participants -- by application of surplus -- for the first year in anticipation that a high percentage of CDIP members would continue the coverage in ensuing years. This would have the advantage of "positive billing" without having to bill in the first year on that basis.

The coverage would be made available on a premium paying basis for CDA members who are not currently participating in the life plan. Of course, surplus also could be applied to pay for such coverage in the first year, although that approach could raise questions of equity.

- Issuance of insurance should only be to those under age 65 and actively at work at the date of issue.

Subject to these conditions, we prefer the third proposal offered by Imperial Life.

Following our analysis of Imperial Life's proposals, the Management Committee recommended that the amount available under the open enrolment be increased to \$20,000. Imperial Life has advised that this change does not alter its underwriting proposals. Therefore, based on current life premium rates, the draw-down from Life surplus in the first year to provide coverage for CDIP participants would be approximately \$350,000. Given that this coverage would be free, there should be no immediate need to increase the Life RSR. However, we recommend that \$1,000,000 be allocated from surplus as a special contingency fund reserve to offset additional claims costs which are likely to occur within the uninsurable group of participants who elect this coverage.

3. Promotion of Conversion Option

The conversion option which is available when amounts of life coverage are subject to reduction would be actively promoted.

Commentary

The promotion of the conversion option will presumably lead to an increase in the number of conversions. To date, the incidence of conversion has been very low and Imperial Life has not required the charge which is typically assessed to a group life account at the time of a conversion.

If the incidence increases significantly, it is probable that Imperial will attempt to negotiate for conversion charges. There are no statistics available from which we can quantify the charges with a high degree of accuracy. The incidence of conversion under "group" life contracts is somewhat less than 1%. Although there are no statistics available for individually underwritten association coverage, we contacted a major association underwriter and learned that only 2 conversions had ever taken place in their entire book of association business.

Given the absence of relevant statistics we believe that it is conservative to assume that there would be one conversion per year, on average, at age 65. Assuming an average certificate of \$150,000, the amount available for conversion would be \$75,000 (50% of \$150,000). The estimated conversion charge applicable at age 65 is \$200 per \$1,000 of converted insurance. The average conversion charge would, therefore, be \$15,000, a rather insignificant amount compared to the total annual life premium under CDIP. It should be noted, however, that if a number of participants with more than the average coverage elect to convert in one year, the effect on the financial experience could be significant in that particular year.

Given that Imperial Life will attempt to negotiate for conversion charges if the incidence of conversion increases, it would be prudent for CDSPI to encourage the participants to apply for insurance on a medical evidence basis. This approach would minimize potential conversion charges and may offer a broader range of products and premium rates to the healthy participants. If uninsurable, the conversion option would still be available during the 31 days following the reduction date.

It is possible that a healthy participant who shops the insurance marketplace will be able to find more competitive rates than those offered by Imperial Life. If the CDA wishes to provide favourable rates to participants for the insurance reduction which occurs at age 65, we recommend that consideration be given to subsidizing the individual premium rates which would normally apply. Presumably, this could be done by means of an allocation from surplus. In any year, the draw from the contingent allocation would equal the subsidy required to meet the difference between Imperial Life's individual premium requirements and the discounted premium available to CDIP participants.

The approach outlined in the foregoing paragraph has the advantage of extending favourable premium rates to individuals who have contributed to the surplus during their periods of participation regardless of their state of health. We note, however, that such an approach would require the underwriter's approval. While we cannot accurately quantify the cost of this alternative, we believe that a one-time allocation of surplus of \$250,000 should be adequate for the foreseeable future.

Consideration could also be given to extending the reduction dates by 5 years, thereby postponing the first compulsory reduction to age 70. If a participant postpones retirement until age 70 he/she would then have the option of continuing full coverage until 70 without the necessity of converting or otherwise buying individual coverage. The Plan would, however, be exposed to additional risk during the deferral period.

Imperial Life was not requested to provide its approval or advice with regard to the conversion option alternatives since it was felt that any approach would have drawn attention to the current absence of conversion charges.

4. Elimination of Pooling

The current \$300,000 pooling limit would be increased or eliminated.

Commentary

The financial consequences of this are discussed in detail in our February, 1987 report. Imperial Life has confirmed that they would be prepared to increase the pooling limit or eliminate it entirely, as approved by the CDA.

5. Increase of Life Maximum

The current \$510,000 life coverage maximum would increase to \$600,000, \$700,000 or \$750,000.

Commentary

The suggested increase in the maximum amount of coverage available to a participant would undoubtedly prove appealing to a number of the 312 participants who are currently insured for \$510,000. It also would be attractive to those participants whose insurance needs are escalating rapidly.

Imperial Life has confirmed that it would be willing to underwrite coverage up to \$750,000.

In Section III of our February, 1987 report, we examined in detail the effects that an increase in the Life coverage maximum would have on the objective Rate Stabilization Reserve and the rather minor increase in the risk of deficit in any year under the Life plan.

We therefore recommend that the Life plan be fully experience-rated. This move would have no impact on the level of surplus now held under the plan.

6. Temporary Bonus Life Coverage

- a) Additional basic Life - increase all insured amounts under the plan by, say, 10%. Coverage would be continued for a year or two, with further renewal as resources permit.

Commentary

Imperial Life has confirmed that this change would be acceptable, and that the regular premium rate schedule would apply. An increase of 10% in current levels of coverage would necessitate an annual infusion of approximately \$310,000 from the Life surplus.

- b) Transitional income benefit - an amount equal to, say, 10% of the face amount of the policy would be paid in monthly installments in each of the first two years following the death of the insured. It would be paid to the normal beneficiary or commuted and paid in a lump sum to the estate if no beneficiary is named.

Commentary

Imperial Life's initial reaction was that they would prefer not to provide additional coverage in this manner. In their words, "Apart from additional administrative procedures, we feel that this type of payment from life insurance proceeds is no longer a common practice especially at the professional level where arrangements are usually made on a more practical basis by use of a will."

Our reply to them was that a temporary income benefit of this nature could be a very attractive addition to the plan if the administrative costs were not too great. We therefore requested that they reconsider the matter.

For a transitional benefit of 10% of the face amount, payable in monthly installments for two years, Imperial Life has quoted the following charges:

- i) For each claim, a single premium of \$22.62 per \$24.00 of capital sum paid over the two year period;

e.g. \$120,000 face amount
\$ 12,000 transitional benefit at \$500 per month
\$ 11,310 single premium charge

- ii) For each claim, a single payment of \$900 to cover administration costs;

- iii) The minimum face amount would be \$50,000 (i.e. \$5,000 transitional benefit). The commuted value would be paid to the estate if there is no named beneficiary, or if the transitional benefit is less than \$5,000.

As evidenced by their quoted administration charge of \$900 per claim, Imperial Life is not very receptive to this benefit. The rate of \$22.62 per \$24.00 assumes a 7% basis of commutation which is reasonably competitive. Based on current levels of participation in the Life plan, the Transitional Income Benefit would require an annual infusion of approximately \$295,000 from the Life surplus.

7. Free Retiree Life Coverage

If an insured's basic life coverage has been in effect for the period from age 50 to age 65, the participant would be covered on a non-premium paying basis for the first \$25,000 between ages 65 to 70, \$15,000 to age 75 and \$10,000 to age 80.

Commentary

Imperial Life has no objection to underwriting this benefit. They suggested that the free benefit could be expressed as a percentage (e.g. 10%) of the insurance in force. They also suggested that at age 80 participants could receive \$5,000 of paid-up insurance. Their quoted single premium at age 80 per \$1,000 of insurance was \$594 for males and \$530 for females, prior to the CDSPI administration fee.

Based on current participation in the Life plan by those age 65 and over, the annual premium for the "\$25,000/\$15,000/\$10,000" proposal would be approximately \$160,000. The annual premium for the "10%" approach suggested by Imperial Life would be \$20,000. In either case, costs would increase in future years as more participants enter the over-65 age category. The proposed paid-up benefit would not be costly because there are only one or two members presently attaining age 80 each year.

8. Premium Credits - Current Surplus

The current life premium credit system could be continued or even expanded.

Commentary

It does reduce the amount of premium flowing to the plan -- at least in the short term. Nevertheless, it would be a very attractive feature of CDIP, particularly in these times of spiralling general insurance costs. Obviously, since the only change would be that some of the total premium is being funded from existing surplus, we did not have to obtain the approval of Imperial Life. The current premium credit amounts are being entirely funded from interest earnings on the Life surplus, augmented by experience gains in favourable years. The interest on the surplus during 1986 was, however, offset by a current year deficit and an increase in the contingency reserve requirement. Therefore, no premium credit is available in respect of the 1986 policy year. A copy of our report concerning the 1986 premium credit is provided as Appendix A.

9. Guaranteed Life Rates

Life rates would be offered to participants on the basis that they are guaranteed for 5, 10, 15 or 20 years. Such guarantee would specify the maximum rates which could be charged by Imperial Life. Premium rates could be reduced during the guarantee period if experience warrants such rate action.

Commentary

Given that the life insurance account has enjoyed favourable experience over most years in the past, we are of the opinion that it is highly unlikely that a rate guarantee would be required to maintain the current rates over the long term period. Nevertheless, we expect that a rate guarantee would have a very favourable marketing impact.

The financial considerations of this proposal are detailed in our letter of January 19, 1987 which is included as Appendix B to this report.

10. Life/LTD/OOE Rate Guarantees

All premium rates for the Life, Long Term Disability and Office Overhead Expense coverages would be guaranteed for a period of 5 years.

Commentary

The stability of the entire CDIP program, not simply its individual components, is of primary importance. This statement applies not only from the standpoint of the CDIP participants, but also from that of the Canadian Dental Association, CDSPI and its Board of Directors and finally, Imperial Life as underwriter.

In our report of January 30, 1987, we recommended that an overall increase of 15% should ensure the continuing financial stability of the Long Term Disability plan in the years ahead. For the following reasons,

it is our opinion that the proposed 5-year premium rate guarantee be introduced at the same time as, or immediately following the proposed LTD rate increase:

- The LTD premium rate structure has been stable for many years, and any increases are likely to prompt renewed criticism by agents and insurers who offer competing individual LTD coverage.
- The participants in the LTD plan must be convinced that one premium rate increase is not the beginning of a series of such increases.

We therefore asked Imperial Life to confirm that an increase of 15% in the LTD rates, commencing January 1, 1988, would be acceptable. In addition, we communicated to them our proposal that the Life, LTD and OOE premium rates be guaranteed for 5 years commencing in 1988 (allowing for the 15% LTD rate increase). We asked them to confirm their acceptance to the rate guarantee, subject to any changes in the underwriting arrangements which they felt were necessary under the circumstances.

It was Imperial Life's opinion that the trend of LTD experience in the last several years is such that a 15% LTD premium rate increase would not be adequate. Their proposal for the 1988 policy year was a 30% rate increase. If this premium increase were to be met by a direct rate increase of 15% coupled with an equivalent draw-down from Disability surplus, the draw-down for 1988 would be approximately \$625,000, based on current LTD plan participation.

Suffice it to say that Imperial Life was very reluctant to agree to a 15% increase in the LTD rates and to guarantee premium rates even beyond one year. After a number of discussions with Imperial Life, we have received the following proposal:

- a) The LTD rates would be increased 15% effective January 1, 1988.
- b) All rates for the Life, LTD and Office Overhead coverage would be guaranteed for a 3-year period commencing January 1, 1988.

- c) As has been previously negotiated with Imperial Life, the plan is committed to restocking the disability RSR (Rate Stabilization Reserve), if required, by a maximum draw-down from surplus of approximately \$1,300,000 at December 31, 1987.
- d) On January 1, 1988, there would be the following transfer from surplus into the combined RSR's for the Life and Disability accounts:
 - i) If the combined Life/Disability RSR is positive, transfer \$3,000,000. (Presumably, the CDA would transfer the estimated \$2 million that will be available in the Disability surplus account, plus \$1 million from the Life surplus account).
 - ii) If the combined RSR is negative, the amount to be transferred would be \$3,000,000 plus the negative amount.
- e) All Life and Disability benefits would be cross experience-rated for the 3 year guarantee period.
- f) There would be a full accounting at the end of the 3-year period; during the three year period there would be no interim transfers into the surplus accounts.
- g) The contingency charge in the retentions would be 0.75% of net premium, as opposed to the present 0.50% charge. In addition, there would be no pro-rating of the contingency charge depending on the funded level of the RSR.
- h) Noting that they had been asked to confirm their acceptance of a number of possible plan changes, Imperial Life stated that they reserved the right to make a final confirmation of these financial arrangements depending upon the changes ultimately adopted by the CDA.

Our commentary regarding the Imperial Life rate proposals is as follows:

- After taking into account expenses and interest credits, the loss ratios on the LTD over the past 5 years have been as follows:

	<u>Loss Ratio</u>
1986	107%
1985	135
1984	78
1983	107
1982	101
Aggregate	106% *

- * If the reserve strengthening in 1986 (estimated to be \$700,000) is included, the aggregate loss ratio increases to 110%.

Only one year (1985) would suggest that a 30% rate increase is appropriate. Our opinion continues to be that a 115% rate increase is appropriate in the circumstances, and recognizes some deteriorating claims trend.

- If the loss ratios were to be 115% of premium throughout 1987 and the proposed 1988-1990 rate guarantee period, relative to current LTD premium levels a total dollar loss of \$2.5 million would be experienced. However, Imperial Life is in effect requesting the following financial resources to offset possible adverse claims experience relative to current premium levels:

	<u>\$ Million</u>
Current Life RSR	\$ 0.8
Current Disability RSR	0.2
LTD Premium increase	1.8
1987 Maximum LTD draw-down	1.3
Special RSR (minimum)	<u>3.0</u>
Total	\$ 7.1

In addition, under the Imperial Life proposal the "Special RSR" of \$3.0 million from surplus could be increased, depending upon 1987 experience. Further subsidization from the Life to the Disability accounts could also result due to cross-experience rating. Finally, there would be a minimum add-on of \$20,000 per year to the contingency charges in the retention.

- Under the Imperial Life proposal, the extent of the possible Life subsidization of the Disability account is not guaranteed:
 - As noted above, the Special RSR of \$3.0 million might be increased and require additional support from Life surplus.
 - Depending upon Life/Disability experience during the 1988-1990 guaranteed period, cross-rating could result in additional funds flowing from the Life plan to the Disability plan (or vice-versa).

Our overall assessment is that the Imperial Life proposals are unsatisfactory. If the 30% LTD increase on a one-year basis cannot be reduced in the course of future negotiations, we recommend that half of the increase be met by application of Disability surplus. Their proposal for the 3-year guarantee period -- however favourable this approach would be from a marketing perspective -- is far too expensive.

Following the Management Committee's review of Imperial Life's proposals a counter-proposal was put forth on behalf of the Committee at a meeting held on May 11, 1987 with Imperial Life representatives. Such proposal follows:

1. The LTD rates would be increased 15% effective January 1, 1988.
2. All rates for the Life, LTD and Office Overhead coverage would be guaranteed for a three-year period commencing January 1, 1988.
3. The reserve bases and retention formulae would remain as presently constituted throughout the three-year period.

4. On January 1, 1988, \$3 million of the surplus would be set aside as a special contingency reserve. At the end of the three-year period, this amount with accumulated interest would be available to offset any combined Disability account deficit.

5. There would be no cross experience-rating of the Life and Disability accounts.

Imperial Life will present its reply in a meeting with the Management Committee on May 20th.

* * * * *

III. SUMMARY OF FINANCIAL CONSIDERATIONS

The annual financial experience report prepared by Imperial Life indicates that there is a surplus of \$5,889,739 as at December 31, 1986. Of this amount, \$1,214,000 is set aside as a "special reserve" as a contingency for possible future adverse experience. The net effect is an unallocated surplus of \$4,675,739.

Before summarizing the financial considerations of the alternatives discussed in this report, it is necessary to estimate the previously approved withdrawals from the surplus. These items are detailed following:

1986 Underpayment of Smoker Subsidy	\$ 53,000*
1987 Premium Credit in respect of 1985 surplus	658,000
1987 Graduates Coverage	<u>10,000</u>
	<u>\$721,000</u>

* Due to error in Imperial Life statement.

Although it is not possible to identify precisely the amounts required to implement the suggestions outlined in this report, we have prepared estimates for your information. A summary of those estimates follows on the next page.

Estimated Draw from Surplus

<u>Action</u>		<u>Annual</u>	<u>One Time Draw or Present Value of Annual Draws</u>
i)	Open Enrolment		
	a) Premium	\$ -	\$ 350,000
	b) Contingent Allocation	-	1,000,000
ii)	Promotion of Conversion	-	250,000
iii)	Full experience-rating with current \$510,000 maximum	-	125,000
iv)	Increase maximum coverage to \$750,000 with full experience rating	-	15,000
v)	Temporary Bonus Life	310,000	3,100,000
vi)	Transitional Income Benefit	295,000	2,950,000
vii)	Free Retiree Coverage	160,000	1,600,000
viii)	3 Year Rate Guarantee	-	1,500,000
ix)	Graduates Coverage	<u>10,000</u>	<u>100,000</u>
		<u>\$775,000</u>	<u>\$10,990,000</u>

The estimated draw of \$125,000 required for the elimination of the current pooling level simply represents the additional amount which would be required to fund the RSR to its revised objective level. Item iv, is the additional amount of RSR required if both the maximum coverage and experience rating level are increased from \$510,000 to \$750,000. Generally speaking, these amounts could be recovered from in-year surplus as it arises. However, it is probable that the underwriter would attempt to negotiate a contingent amount from surplus.

The proposed \$1,500,000 draw from the Life surplus for the 3 year rate guarantee assumes that the other \$1,500,000 would be drawn from the Disability surplus account.

* * * * *

CANADIAN DENTISTS' INSURANCE PROGRAM

LIFE PREMIUM RATE CREDIT PROGRAM - 1988

Kenneth T. Ransby
Janet I. Zwarick

May 5, 1987

INTRODUCTION

In a report dated August 29, 1985, we recommended that an annual Life account premium credit be determined as follows:

- (a) In each year, determine the amount of interest earned (I) on the Life surplus for the year, and any new experience gains (E) which increase the Life surplus account.
- (b) Determine the premium rate subsidies (S) for the year.
- (c) Determine the amount required (R) to increase the special contingency reserve (now \$1,054,000) to 50% of the current annualized net experience-rated premium.
- (d) The surplus available for distribution in the ensuing year would then be equal to:

$$\text{Distributable Surplus} = I + E - S - R$$

- (e) The total "distributable surplus" thus determined would be reduced by any transfers from surplus authorized by the CDA to increase the Rate Stabilization Reserve or to meet any new premium subsidies under the Plan.
- (f) Allocations would be made to the individual Plan participants, based upon a method adopted by the CDA.

On October 5, 1985, the Board of Directors approved this distribution formula, and approved the premium credit method of distribution. Based on the above distribution formula, a Life premium credit equal to 23.8% of the 1987 gross Life premium otherwise due, was implemented.

The purpose of this report is to determine the amount of surplus which could be distributed as a premium credit and applied to invoices for premiums due January 1, 1988.

DETERMINATION OF DISTRIBUTABLE SURPLUS

By utilizing the formula stated in the previous section, the distributable surplus arising in 1986 was determined as follows:

- (a) During 1986, there was approximately \$615,000 in interest earned on the Life surplus.

i.e. $I = \$615,000$

However, there were no new experience gains which increased the Life surplus account.

i.e. $E = 0$

- (b) The premium rate subsidies for the year were approximately \$462,000.

i.e. $S = \$462,000$

- (c) As at the end of 1986, the annualized net experience-rated premium was approximately \$2,428,000. The new level of the special contingency reserve is then 50% of this amount, or approximately \$1,214,000. The increase in this reserve from the former \$1,054,000 level, is then \$160,000.

i.e. $R = \$160,000$

- (d) The surplus available for distribution is then equal to:

$$\begin{aligned}\text{Distributable Surplus} &= I + E - S - R \\ &= 615,000 + 0 - 462,000 - 160,000 \\ &= -\$7,000\end{aligned}$$

The distributable surplus is therefore nil, and \$7,000 must be applied from unallocated surplus to maintain the special contingency reserve at the objective level. Next year, this \$7,000 could be factored into the analysis if the unallocated Life surplus is to be maintained at the 1986 level.

In summary, the interest earned on the Life surplus was fully applied to pay for the premium rate subsidies and to increase the special contingency reserve to the objective level. Unlike the previous year, there were not experience gains available to produce a premium rate credit for the 1988 plan year.

TOWERS, PERRIN, FORSTER & CROSBY

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Our Ref: 00669/006

January 19, 1987

Mr. Kingsley D. Butler
Executive Vice-President
Canadian Dental Service Plans Inc.
Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

Re: Guaranteed Life Rates

This is in response to your letter of December 10, 1986 concerning the above subject.

If you were to offer Guaranteed Life Rates to participants in CDIP, we envisage that two alternative approaches could be considered:

1. Pooled Method

The underwriter would guarantee fixed premium rates which would apply to all amounts of insurance which are to be subject to the guarantee. The insurance would be fully pooled, i.e. the underwriter would absorb any deficits or keep any surpluses arising from this book of business.

We estimate that Imperial Life would be prepared to offer a long-term guarantee of perhaps 20 years in exchange for premium rates which would not exceed 110% of the present rates. Presumably, a lower charge such as 105% would apply in the case of a shorter guarantee period such as 5 years, with charges in the 105% to 110% range for intermediate term guarantees of 10 years and 15 years.

Subject to negotiation with Imperial Life, the guaranteed premium would apply to present amounts of insurance for the term of the guarantee, and to newly issued insurance for the same term if it is issued within a relatively short period in the future -- say, two or three years. Beyond that period, the premium rate schedule for new guaranteed life insurance would be subject to negotiation.

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2. Experience Rated Method

The underwriter again would offer fixed premium rates which would apply to all amounts of insurance which are to be subject to the guarantee. The insurance would be experience rated, in the sense that any surpluses at the end of the guarantee would revert to CDIP. The underwriter would absorb any deficits.

Since the experience rating method would be one-way in nature, Imperial Life no doubt would insist that a higher rate schedule should apply than in the case of the pooled method -- say, 115% of the present rates for the 20 year guarantee. The charge would be about 110% for the 5 year guarantee, and the charges for the 10 year and 15 year guarantees would be in the 110% to 115% range.

As in the case of the pooled method, the guaranteed premiums would apply to present amounts of insurance for the term of the guarantee, and to newly issued insurance for the same term if it is issued within the next two or three years. Beyond that period, the premium rate schedule for new guaranteed life insurance would be subject to negotiation.

Whether the guaranteed life rates are offered on a pooled basis or an experience rated basis, the question remains as to whether existing surplus should be applied to support the program and if so, how much surplus is to be allocated. The major considerations are as follows:

(a) Optional vs. Compulsory

If guaranteed life rates are to apply to all members, it would be reasonable to allocate surplus to support the program. Assuming that the existing surplus would earn interest at 9% per year and that the volume of insurance increases at a rate of 5% per year, about \$4.1 million of existing surplus would be expended over a 20 year period under the pooled method. About \$6.1 million would be applied under the experience rated method, but the surplus would be re-stocked to the extent that there is an experience rating surplus at the end of the guarantee period.

If the guaranteed life rates were to apply only to those participants who elected such coverage, it would be equitable to increase premium rates paid by the electing participants. For instance, 50% of the extra cost could be met by additional premium and 50% by application of surplus. Application of existing surplus for electing participants could be justified on the basis that only non-electing participants would be entitled to lower premium rates resulting from the emergence of future surpluses under the plan.

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TOWERS, PERRIN, FORSTER & CROSBY

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(b) Length of Guarantee

As noted above, it is likely that Imperial Life would insist upon higher premium rates as the term of the guarantee is lengthened. This is notwithstanding the fact that there has been a steady decrease in rates of mortality in recent years and that this trend is likely to continue with advances in medical science.

Therefore, it should be kept in mind that the insurer's margins are likely to increase as the term of the guarantee is lengthened, unless premium rates are gradually reduced over time.

Given that the life insurance account has enjoyed favourable experience for many years, we are of the opinion that it is highly unlikely that the experience will deteriorate over any period which is long enough to eliminate random fluctuations which can occur from year to year. Nevertheless, we expect that a rate guarantee would have a very favourable marketing impact. Consequently, we recommend that any guarantee should have the following characteristics:

- The rate schedule should be guaranteed for a period such as 5 years which is long enough to have a positive marketing impact without potentially locking-in unnecessary margins.
- The premium rate guarantee should apply to all insurance, thereby simplifying plan administration, and should be experience-rated in the manner noted above.
- The five year guarantee should apply to all present amounts of insurance and to amounts purchased over the next two or three years. The guarantee should be reviewed every two or three years in order to keep all amounts guaranteed if possible.
- The cost of the guarantee should be met by a contingent allocation of surplus, rather than by a direct premium increase. In other words, the special 5% or 10% charge would be identified, accumulated with interest and would be available to Imperial Life over the guarantee period only if the plan's experience were to deteriorate.

* * * * *

I would be pleased to discuss this matter further with you and/or the members of the Management Committee at your convenience.

Yours very truly,

TPF&C LIMITED

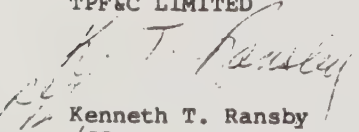

Kenneth T. Ransby
/cc

EXHIBIT 1

TRACKING OF CDIP LIFE SURPLUS JANUARY 1, 1978 TO DECEMBER 31, 1986

	<u>EXPERIENCE</u>		<u>INVESTMENT</u>		<u>SPECIAL</u>	<u>TOTAL</u>
	\$	%	\$	%		
Balance Jan 1/78	N11		N11		N11	N11
1978 Results	<u>616,795</u>	57.2	<u>462,293</u>	42.8	<u>-</u>	<u>1,079,088</u>
Balance Dec. 31/78	616,795	57.2	462,293	42.8	-	1,079,088
1979 Results	<u>64,537</u>	20.4	<u>251,199</u>	79.6	<u>-</u>	<u>315,736</u>
Balance Dec. 31/78	681,332	48.9	713,492	51.1	-	1,394,824
1980 Results	<u>294,430</u>	43.9	<u>376,406</u>	56.1	<u>-</u>	<u>670,836</u>
Balance Dec. 31/80	975,762	47.2	1,089,898	52.8	-	2,065,660
1981 Results	<u>(425,874)</u>	(467.0)	<u>517,063</u>	567.0	<u>-</u>	<u>91,189</u>
Balance Dec. 31/81	549,888	25.5	1,606,961	74.5	-	2,156,849
1982 Results	<u>23,219</u>	3.1	<u>717,280</u>	96.9	<u>-</u>	<u>740,499</u>
Balance Dec. 31/82	573,107	19.8	2,324,241	80.2	-	2,897,348
1983 Results	<u>480,601</u>	44.1	<u>610,073</u>	55.9	<u>-</u>	<u>1,090,674</u>
Balance Dec. 31/83	1,053,708	26.4	2,934,314	73.6	-	3,988,022
1984 Results	<u>291,226</u>	29.0	<u>714,237</u>	71.0	<u>-</u>	<u>1,005,463</u>
Balance Dec. 31/84	1,344,934	27.0	3,648,551	73.0	-	4,993,485
1985 Results	<u>(180,261)</u>	(26.3)	<u>864,756</u>	126.3	<u>-</u>	<u>684,495</u>
Balance Dec. 31/85	1,164,673	20.5	4,513,307	79.5	-	5,677,980
1986 Results	<u>(403,505)</u>	(190.0)	<u>615,264</u>	290.0	<u>-</u>	<u>211,759</u>
Transfer to Special Reserve	<u>-</u>		<u>(1,000,000)</u>		<u>1,000,000</u>	<u>0</u>
Balance Dec. 31/86	<u>\$ 761,168</u>	12.9	<u>\$4,128,571</u>	70.1	<u>\$1,000,000</u>	<u>17.0 \$5,889,739</u>

EXHIBIT 2

LIFE SURPLUS AS AT DECEMBER 31, 1986 - BY PROVINCE
 BASED ON EXPERIENCE vs PREMIUM PAID SINCE 1978

PROVINCE	1985		1986	
	\$	%	\$	%
B.C.	1,045,000	18.4	1,096,114	18.6
ALBERTA	715,000	12.6	757,961	12.9
SASKATCHEWAN	324	-	(10,889)	(.2)
MANITOBA	258,000	4.5	270,735	4.6
ONTARIO	2,993,000	52.7	3,134,564	53.2
QUÉBEC	296,000	5.2	261,682	4.4
NEW BRUNSWICK	208,000	3.7	222,372	3.8
PRINCE EDWARD ISLAND	70,000	1.2	65,504	1.1
NOVA SCOTIA	(160,000)	(2.7)	(179,455)	(3.0)
NEWFOUNDLAND	99,000	1.7	103,844	1.8
OTHER	<u>154,000</u>	<u>2.7</u>	<u>167,308</u>	<u>2.8</u>
	5,678,324	100.0	5,889,740	100.0

Robert H. Apsey

7 Deanewood Crescent
Islington, Ontario
M9B 3A9

May 13, 1987

The Management Committee
Canadian Dental Service Plans Inc.
Suite 600
2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Sirs:

In accordance with Dr. Durran's letter of March 23, 1987, CDA has requested from CDSPI its recommendations for dealing with the current surplus under the Insurance Program. The material and information which Mr. Butler forwarded with his letter of April 16, 1987, has been carefully reviewed and hopefully my comments will be helpful to the Committee in making its recommendations to CDA.

As original consultant for the revised Insurance Program in 1977, it was pleasing to learn that the Program continues to enjoy much success on a financially sound basis. Unfortunately, many Associations do not enjoy the same success, primarily because of the uncertain environment related to participation and the constant change of decision-makers, which leads to poor management of Programs. Having been involved with a number of Association Insurance Programs in the past, I feel well qualified to address your current concerns with respect to the surplus under three main headings:

- 1) Participation
- 2) Underwriting
- 3) Recommendations.

1) Participation

It is noted from the material forwarded by Mr. Butler that Life gross premiums have increased from \$1,241,000 in 1978 to \$3,100,000 in 1986. Your Disability gross premiums have also increased substantially from \$2,575,000 in 1978 to \$6,701,000 in 1986. With respect to the Life premium, the increase has been accomplished along with the following rate reductions:

2.

1980 - 10% reduction in basic Life rates
1982 - 10% reduction in basic Life rates
1984 - 8% reduction in Life rates for non-smokers
1985 - 10% reduction in Spousal Life rates
- 25% reduction in Life rates for non-smokers
1986 - 23.8 premium discount on Life premiums for 1987.

I suggest the significant growth in premium from 1978 to 1986 is attributable to the following:

- 1) very competitive rates with favourable negotiated contract provisions,
- 2) an excellent communication and administration system,
- 3) a sound financial position which permits incentive promotions and rate reductions from time to time.

A conventional insurance program sponsored by an employer for its employees usually provides mandatory coverage which insures that all employees participate in the program. This eliminates the voluntary aspect and, as might be anticipated, insurers prefer this type of business. A voluntary Association Program must continue to develop premium income through increased coverage and new participation. Regarding the latter, the addition of new and perhaps younger dentists spreads the risk and helps to insure conformity to mortality and morbidity tables being utilized by the underwriter.

In considering participation, obviously rates and contract provisions must be better than competitors who stress personalized service by their agents. In my opinion, a portion of the accruing surplus should be utilized at appropriate times to provide holiday premiums, incentives and discounts, primarily in the Life plan to insure increased coverage and new participation in future years. A number of Association Plans have not had the luxury of a surplus, with the result that the membership and coverage become static leading to financial problems and ultimate cancellation of the Plans by the insurers. In my opinion, utilization of a portion of the surplus in this manner is essential to the CDA Program continuing on a sound financial basis, thus benefiting all members of the Program.

2) Underwriting

Although one would not anticipate a change in underwriters, the possibility always exists for one reason or another. Not only does a surplus provide negotiating power with your existing insurer, it may be essential in negotiating rates and contract provisions with a new insurer. As indicated previously and as you may recall when tendering in 1977, the market is very limited for Association plans, primarily because of voluntary participation and adverse experience. Without a surplus to immediately establish a Rate Stabilization Fund, tendering insurers may not agree to underwrite the Disability coverage without the Life coverage. As you will appreciate, transfer of the Life coverage to another insurer presents real communication and administrative problems in that the individual policies may have to be signed off by the policyholders. Let us not forget that the proceeds of many of these policies have been assigned for loan purposes.

Suffice to say at this time that a surplus provides negotiating power now and in the event of any transfer which may be necessary at some future date.

3) Recommendations

The surplus under the Life and Disability Plans as of December 31, 1986, was approximately \$8,440,000. Interest rates have been high in recent years and pension funds in particular have accumulated significant surpluses. Certainly, the CDA program also benefited from high interest rates in the past which contributed significantly to your current surplus. With rates leveling off more recently, it will impact on future investment earnings under these Plans.

In regard to what may be considered a maximum surplus under the Program, the Department of National Revenue indicates an employer must take action to reduce surplus when such surplus under a Pension Plan exceeds two years of contributions.

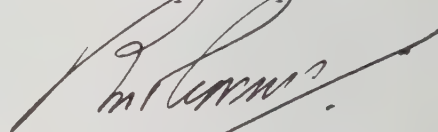
In many instances, the employer, on the advice of its actuary will make improvements to the Plan along the way and prior to reaching this maximum surplus. While admittedly a pension plan differs from an insurance plan, both plans develop surpluses mainly through investment earnings. Accordingly, I would regard two years of premiums (approximately \$16,000,000) as a maximum surplus under your Association Program. As in the past, however, you should continue to utilize a portion of your accruing surplus in developing new premium income. At no time, in my opinion, should any portion of surplus be paid in cash for other reasons such as

- 1) tax on payment,
- 2) the problem of establishing an equitable formula,
- 3) the expenses associated with calculation, issuance and mailing of cheques.

Finally, the surplus should be looked upon as arising under the entire Program and not related to any particular Plan. The surplus must be used for any Plan which is temporarily (hopefully) developing poor experience. To allow your L.T.D. rates, for example, to become non-competitive is simply inviting your good medical risks to transfer their coverage to another insurer. With a foot in the door, the agent then proceeds to sell other coverages which ordinarily would have been purchased under the CDA Program. A gradual increase in the L.T.D. rates with temporary support from the surplus serves all participants in the long run by insuring the purchase of coverage on a competitive basis under a financially sound Program.

I shall be pleased to meet with the Committee at its convenience to finalize recommendations if such is considered desirable.

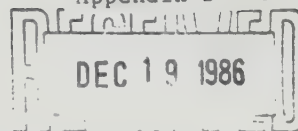
Yours very truly,



R.H. Apsey
Insurance Consultant

/jg

**THE LAURENTIAN GROUP
CORPORATION**



Robert E. Brown
Vice-President
Marketing

December 17, 1986

Mr. Kingsley D. Butler, C.A.
Executive Vice-President
Canadian Dental Service Plans Inc.
Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

First, let me apologize for my tardiness in responding to your letter of November 11, 1986. I intended to respond promptly, however, got tied up in a number of business trips and finalizing 1987 business plans, and unfortunately your letter got buried in the detail. I trust you and the members of the Management Committee will forgive me for my tardiness.

I am taking the liberty of responding to your request in lieu of the fact that Imperial Life has not yet replaced their Vice-President of Group Marketing, and I am likely the most conversant with the plan and the management style of CDSPI.

The maintenance of a plan surplus in an account the size of CDSPI, with a life insurance company, definitely provides stability in the dealings that you have with your insurer and does permit you the opportunity to stabilize and maintain rates.

The plan that is in existence with your organization represents the amalgamation of individuals with a professional affinity that allows them to buy life insurance, and disability insurance on a wholesale basis under the definition of "Group Insurance". Group insurance is normally designed for employees where enrollment in the plan is a condition of employment, and the economies of purchasing benefits on this basis narrow the anti-selection because of the fact that it is purchased on a compulsory basis. Under the definition of true group, an insurer would normally build into its price, for larger groups, a margin in the neighbourhood of 3% to 5%, that would then allow the policyholder to share in the profits or losses of the plan, and the aforesaid margin that is built into the price is used to build up a stabilization reserve that provides some degree of margin

...2

Mr. Kingsley D. Butler, C.A.

Page 2

December 17, 1986

against the potentials for profit or loss. In the event that the experience is better than expected, a portion of this margin is then refunded to the client and the balance is left in a rate stabilization reserve for years in which the experience is not as anticipated in the pricing. Group insurance by its nature is cyclical, tied heavily to economic factors, employment rates, various industry success factors in which the individual employer finds himself, etc. etc.

The CDSPI plan has had several years of very successful performance and as a result has been able to build up a substantial surplus. In addition, Imperial Life does not have within its rate structure the experience rating margin that most plans would have because of the existence of this surplus, and as a result, your plan has been able to build up a rate stabilization fund as well as free surplus. This allows your insurer not to react immediately when your mortality or morbidity experience shows cyclical deterioration which has been borne out over the past several years where there have been little or no rate increases required. If this surplus was removed, then it would be necessary for Imperial Life or any other insurer to build a margin into their rates to cover the potential of cyclical swings in experience, and as you can appreciate 3% to 5% of your existing premium base is not an insignificant amount of money. The fact that this margin does not exist, then allows CDSPI to share in the total results of the plan, and Imperial Life then is left with operating on fixed margins that are clearly definable for the administration of your plan.

Another major feature associated with the existence of the surplus allows CDSPI to have a very significant role in the management of the plan itself and more importantly in the adjudication of the claims. As you know, we have had several discussions about the fact that the Management Committee is very prudent in their assessment of disabilities and that their input on claims decisions is or may be stronger than the claims adjudicators have themselves. This opportunity to manage the claims portfolio on a partnership basis is facilitated by the fact that we are managing the plan on a partnership basis and the existence of the surplus facilitates this relationship. If the surplus did not exist and Imperial Life was totally on the risk by themselves for this account, if they were in fact able to do so, then it would make the partnership more difficult.

Whether or not the surplus account needs to be as large as it is currently, is a debatable issue and in fact, in my personal opinion, could be reduced. The concern I have in this regard, however, as I mentioned to you a couple of times, is that if you refunded the surplus to your members, then this would become a taxable item in the hands of each of your members, and I would assume that they would get on average fifty cents on the dollar. There are other options available to you with regard to the disposal of portions of this surplus, however, I do not propose to discuss them in the context of this letter.

...3

Mr. Kingsley D. Butler, C.A.
Page 3
December 17, 1986

In my opinion, the overriding issue supporting the existence and maintenance of this surplus is the ability CDSPI has to weather the cyclical trends in group insurance that are bound to occur, and not have to raise or lower rates on a yearly basis; and are in a position to ride out the cyclical aberrations until such time as they can determine whether or not they are in fact trends that truly support an adjustment in the natural rate basis of your plan.

A typical example for consideration is the potential for a cut-back in the number of graduating dentists coming out of the Canadian educational system. If this eventuality took place, then there would be fewer new, young dentists entering the plan which would result in an aging factor over a period of years within the plan itself which may well affect the overall financial performance of the plan. Statistically this could be proven using actuarial theories. The existence of the surplus, however, allows you to wait a year, two years, maybe longer to determine whether or not there are actually fluctuations in your experience based on the shifting age mix of your members' participation levels.

The bottom line is that if the total surplus was removed, then there would definitely have to be an adjustment in the rates of the various insurance offerings that you presently make available to protect the insurer against fluctuations in mortality and morbidity experience, and the ability of CDSPI to participate fully in the financial rewards of the overall programme would have to be lessened.

I trust these comments will be of some assistance to you and I would welcome the opportunity to discuss them further with you and/or the Management Committee at your convenience.

Yours truly,



R. E. Brown
Vice-President, Marketing

REB/bc



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November 11, 1986

Office of the Executive Vice-President

NOV 13 1986

Mr. R. E. Brown
President, Chief Executive Officer
Eaton Financial Services
595 Bay Street
Toronto, Ontario
M5G 2C6

Dear Mr. Brown

Since your move from St. Clair to Bay Street, it has been difficult to find out your address, as a number of enquiries at Imperial left me with a "I have no idea" answer. However, diligent Imperial ingenuity prevailed, and I trust this letter finds you well, and settled in your new surroundings.

As a result of a discussion with my Management Committee regarding the Canadian Dentists' Insurance Program surpluses, I am writing to ask for your input. I fully realize that this letter should undoubtedly be written to someone else at Imperial, but I feel that because of your knowledge of the Plans, and your growing knowledge of CDSPI and its activities, you should be the first one to approach, and either a response would be forthcoming or an appropriate person at Imperial Life would receive a communication from you to respond accordingly.

The Canadian Dental Association has been working with CDSPI, at the request of their Executive Council, on an investigation regarding the large surplus funds that exist with our Life program. They have basically asked, "How much of a buffer or influence does having a healthy surplus reserve mean in maintaining stable rates for the Life, LTD, and Office Overhead programs?".

Apparently there are those in the provincial ranks that feel there is no need for any surplus, and that it should all be distributed. Our message to them has been that the maintenance of a plan surplus provides stability in the dealings with the insurer, and permits us the opportunity to stabilize and maintain rates. An opinion from a source other than CDSPI on this topic would be appreciated.

The Management Committee felt that you would be the individual to ask, as you gave some similar opinions to Dr. Durran at our dinner meeting earlier this year. Any comments that could be provided either by yourself, or someone from Imperial Life, would be greatly appreciated.

Yours truly

Kingsley D. Butler, C.A.
Executive Vice-President

KDB/dcd

TO: The CDSPI Board of Directors

FROM: The Management Committee

DATE: June 4, 1987

RE: Management of Life Surplus

On page 8 of the current report contained in your Board Book relating to the management of Life Surplus, the following paragraph is presented:

"As at the time of finalizing this report for the Board, one or two small areas are being researched and reviewed with TPF&C and Imperial. A final comment will be presented at the Board Meeting".

As you will recall from having reviewed the report already in your book, Options #9 and #10 contained in the Package Improvements section of the report, related to guaranteed Life rates and Life/LTD/Office Overhead rate guarantees.

In our initial review of the Package Improvements, these areas which we were considering were being further discussed with the insurer.

At the CDA Board of Governors' Meeting in Ottawa in April, Dr. Durran in the presentation of the Council's Report to the Board of Governors, and in reply to a question from one of the Governors, indicated that he concurred with the urgency of having the management of Life surplus matter resolved and back to the Board of Governors as quickly as possible, but wished to inform the Governors that certain options we were exploring still had to be reviewed, discussed and approved by and with the insurer. The speed, therefore, with which resolution could be achieved was still in the hands of the insurer.

The reality of such a statement can be seen once you fully review the actions that have taken place since that statement was made, and since our report contained in your Board Book was prepared.

As our report stated, Imperial Life was approached and asked for their comments regarding a 3-year rate guarantee on Life, LTD and Office Overhead. TPF&C's report, page 15, indicated their initial response and outlined our counter-proposal presented by the Management Committee to Imperial Life on May 11, 1987. As you are aware, this TPF&C report which you have previously read indicated that Imperial Life would be replying to the counter-proposal.

Unfortunately, the response from Imperial Life for a 3-year rate guarantee did not present any great progress in negotiations. As a result, the Management Committee again met with TPF&C, discussed the most recent position of Imperial Life concerning the 3-year guarantee, and decided that the price of this guarantee was too high.

TPF&C was then instructed by the Management Committee to return to Imperial Life and negotiate a 1-year proposal. This proposal would be, in effect, a negotiation for 1988 LTD renewal.

We attach to this report a letter dated June 2, 1987 from TPF&C concerning Imperial's position regarding a 1-year renewal. The Appendix A attached to that letter also outlines a dollar comparison of the proposals that have been going back and forth between CDSPI and Imperial over the past weeks.

As a result of extensive negotiation, the Management Committee must state at this time that, unfortunately, we cannot recommend a 3-year rate guarantee as originally planned.

We feel, however, that renewing for one year, based on the current negotiated formula, will give us an opportunity to look at the experience over the next eight to ten months, see whether or not Imperial Life's predictions for 1987 come true, and during that time period taken an in-depth look at, and provide an analysis of, the LTD experience to determine the causes of its apparent deterioration.

As the TPF&C report indicates, the 1988 "draw down" (meaning the amount that can be accessed by Imperial from surplus regarding any deficit for 1988) is \$600,000. This is the amount the plan would be underwriting the LTD for a one year period, in order to get one more year's experience and review the current plan status in detail.

The Management Committee, therefore, adds one further Motion to those contained on page 14 of our report.

The Management Committee recommends to the CDSPI Board of Directors:

5. "THAT THE LTD PROGRAM BE RENEWED FOR A PERIOD OF ONE YEAR, WITH THE FOLLOWING SPECIAL CONTRACT CONSIDERATIONS:

- THE SPECIAL DRAW DOWN AT THE END OF 1987 WILL BE COMPUTED WITH REFERENCE TO THE NEW OPEN CLAIMS RESERVE BASIS UNDER THE LTD. HOWEVER, AN ALLOWANCE OF \$600,000 WILL BE GIVEN FOR THE CHANGE IN THE RESERVE BASIS THAT OCCURRED AT THE END OF 1986.
- THERE WILL BE A FURTHER CONTINGENT DRAW FROM SURPLUS AT THE END OF 1988, WHICH WILL BE THE LESSER OF:
 - (a) 15% OF NET 1988 LTD PREMIUM; AND
 - (b) THE CUMULATIVE DEFICIT UNDER THE COMBINED DISABILITY ACCOUNT AT THE END OF 1988, BASED ON THE NEW RESERVE BASIS."

The above Motion, along with Motion #1, as contained on page 14 of the report already in your Board Book, covers the terms of the proposed 1988 LTD renewal.

* * * *

As a result of the negotiations with Imperial Life, and the recommendations regarding the LTD renewal, it is necessary to clarify Motion #2, as contained on page 14 of the original report.

This Motion from the Management Committee indicated that the Plan Improvements Option, as outlined in the report, be implemented.

If you refer back to page 9 of the original Management Committee report, the Package Improvements are summarized at the top of that page.

In considering Motion #2, the listing as contained on the top of page 9 should now be amended in order to remove Option #10.

By doing so, the Package Improvement Option is as follows:

Option # 2 - Open Enrollment -	\$1,350,000
Option # 3 - Promotion of Conversion -	250,000
Option # 4 - Elimination of Pooling -	125,000
Option # 5 - Increase of Life Maximum -	15,000
Option # 7 - Free Retiree Life Coverage -	<u>1,600,000</u>
TOTAL DOLLARS DEDICATED TO THE ABOVE BENEFITS FOR PACKAGE IMPROVEMENT OPTION	\$3,340,000

What the above total dollars represent is the setting aside of that amount of money in a special designated area of the Life surplus in order that those funds can remain dedicated to earn the necessary annual interest revenue to fund that particular benefit. It is important that this distinction, as to what happens to these dollars, is clear.

If one takes the estimated total of \$3,340,000, adds to it the Contingency Reserve now in effect of \$1,000,000, and adds to it the estimated cost of issuing a further premium credit discount of \$658,000, and further adds the commitment of \$100,000 as it relates to the dedication of funds to maintain the Graduate Package, the total amount of surplus allocated is \$5,098,000.

As our report has previously stated, the total of Life surplus at December 31, 1986 is \$5,889,739.

- 4 -

We feel that the above is an addressing of the management of Life surplus.

* * * *

The CDSPI Management Committee was asked to attend a meeting with the CDA Management Committee prior to the ODA Convention in Toronto. The purpose of this meeting was for the CDSPI Management Committee to convey to the CDA Management Committee the status of our investigations regarding the matter of the management of Life surplus.

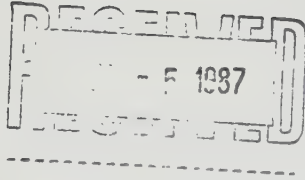
Out of this meeting, five questions arose. The CDSPI Management Committee was asked to obtain a legal opinion regarding these five questions.

Attached is a letter from Beth Moore, dated May 28, 1987 which deals with these five questions and this letter will accompany the Council on Insurance's report to the CDA in order that they may review these responses.

We would ask that you review this document as attached for your information.

/cd

Attachments



TOWERS, PERRIN, FORSTER & CROSBY
250 BLOOR STREET EAST SUITE 1100
TORONTO ONTARIO M4W 3N3
(416) 960-2700

DIRECT DIAL

960-2706

Our Ref: 00669/043

June 2, 1987

Mr. Kingsley D. Butler
Executive Vice-President
Canadian Dental Service Plans Inc.
Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

Re: 1988 LTD Renewal

This is further to my report of May 13th, and to our subsequent discussions with the Management Committee.

As you know, it was decided by the Management Committee that Imperial Life's revised proposal for a 3-year rate guarantee was unacceptable. Not only were the necessary allocations from surplus funds too high, but also Imperial Life insisted that there be a special, open-ended draw-down if there were a cumulative deficit under the Disability plan as at the end of 1987.

We therefore discussed with Imperial Life the financial terms which would be applicable if the Disability plan were renewed for a one year period only. The terms are outlined in the attached letter from Don Jarvis of Imperial Life, and may be summarized as follows:

1. All LTD rates would be increased by 15%, effective January 1, 1988.
2. The special draw-down at the end of 1987 would be computed with reference to the new Open Claims Reserve basis under the LTD. However, an allowance of \$600,000 would be given for the change in the reserve basis that occurred at the end of 1986.
3. There would be a further contingent draw from surplus at the end of 1988. This draw would be the lesser of:
 - (a) 15% of net 1988 LTD premium, and
 - (b) the cumulative deficit under the combined Disability account at the end of 1988 (based on the new reserve basis).

.../2

TOWERS, PERRIN, FORSTER & CROSBY

To: Mr. Kingsley D. Butler
Page: -2-
Date: June 2, 1987

We have the following comments regarding this most recent proposal by Imperial Life:

- o As discussed previously, it is our opinion that a 15% LTD premium rate increase is appropriate in view of actual experience under the plan during the last few years. The additional 15% contingent draw in 1988 reflects Imperial Life's conservative underwriting approach.
- o We are pleased that Imperial Life has agreed to the adjustment in the LTD Open Claims Reserve for purposes of determining the \$1.3 million contingent draw in 1987. We suspect that the new/old reserve differential is closer to \$1 million than the \$600,000 differential negotiated with Imperial Life; however, they insist that they are not able to reproduce the old basis reserve level.
- o We are disappointed that a 3-year rate guarantee could not be obtained at reasonable cost. Although the new proposal establishes a rate guarantee only through the 1988 policy year, it is clear that the amount of surplus to be placed at risk is far less under the most recent proposal than under previous proposals (see Appendix A). In addition, the potential draw from surplus during the 1987-1988 policy years is no longer open-ended.

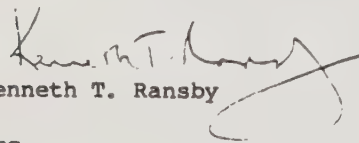
In conclusion, we believe that Imperial Life's final proposal is less than fully satisfactory. Given the 15% LTD premium increase, it was highly desirable that a rate guarantee be implemented to counteract the unfavourable market reaction which is bound to occur. Undoubtedly, Imperial Life is aware that a rate guarantee is desirable from a marketing perspective, but the insurer clearly does not have the underwriting capacity or the willingness to accept the risk of deficit during an extended rate guarantee period. However, it appears that the carrier is willing to accept a one-year risk.

* * * * *

We would be pleased to discuss the above matters with you or the Management Committee at your convenience.

Yours very truly,

TPF&C LIMITED


Kenneth T. Ransby

/cc

APPENDIX A

CANADIAN DENTISTS' INSURANCE PROGRAMDOLLAR COMPARISON OF PROPOSALS
(\$ millions)

	(A)	(B)	(C)	(D)
	Original Imperial Life Proposal	Management Committee Counter- Proposal	Revised Imperial Life Proposal	Imperial Life Final 1988 Renewal Proposal
Current Life RSR	\$0.8	\$ --	\$ --	\$ --
Current Disability RSR ⁽²⁾	0.2	0.2	0.2	0.2
LTD Premium Increase	1.8	1.8	1.8	0.6
1987 Disability Draw-down ⁽²⁾	1.3	1.3	1.3	1.3
Special 1987 Draw-down	1.0	--	1.5	--
Special RSR	3.0	3.0	3.0	--
1988 Disability Draw-down	--	--	--	0.6
Total	\$8.1	\$6.3	\$7.8	\$2.7

- Note: (1) Columns A, B and C represent 3-year proposals which were rejected due to cost. Column D represents a 1-year renewal proposal for 1988.
- (2) The Current Disability RSR and the 1987 Disability Draw-down pertain to experience of the plan and agreements made to date, and do not represent new costs related to the 1988 renewal.

Assumptions: Net LTD annual premium: \$4,100,000

Projected Disability RSR (Deficit) at Dec. 31/87:

-- New reserve basis (\$1,500,000)
-- Old reserve basis (\$ 900,000)

Projected Life RSR at Dec. 31/87: \$500,000

Projected Total RSR at Dec. 31/87:

-- New reserve basis (\$1,000,000)
-- Old reserve basis (\$ 400,000)

June 1, 1987

JUN 02 1987

Mr. Kenneth Ransby
Towers, Perrin, Forster & Crosby
Suite 1100
250 Bloor Street East
Toronto, Ontario
M4W 3N3



The Imperial Life Assurance Company of Canada
95 St. Clair Avenue West, Toronto, Canada M4V 1N7
(416) 926-2600

IMPERIAL LIFE

Dear Ken:

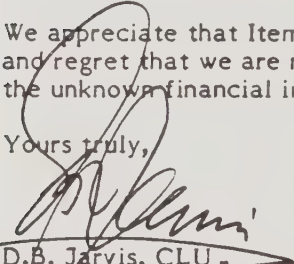
Canadian Dental Association/Long Term Disability Renewal 1988

With reference to our recent discussions, we confirm our requirements as follows:

- 1 All Long Term Disability rates to be increased by 15% effective January 1, 1988.
- 2 An additional amount, up to 15% of 1988 Long Term Disability net premium, available as a "call" on surplus up to the amount necessary to negate any accrued deficit at the end of the 1988 policy year.
- 3 The formula for the R.S.R. to be applied as per contract less \$600,000 (1987).
- 4 Item 2 experience applicable after accounting for the current (1987) agreed formula for call on surplus.

We appreciate that Item 2 is not in accordance with your thinking, and regret that we are not in a position to respond otherwise given the unknown financial implications for the balance of the policy year.

Yours truly,


D.B. Jarvis, CLU
Special Accounts Manager
Group Marketing Department

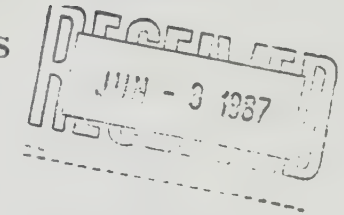
sl

- c - K.D. Butler, C.A.
CDSPI
- P.R. Ferland
- G.H. Hough
- P. Munk

CAMPBELL, GODFREY & LEWTAS
BARRISTERS & SOLICITORS

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A. BETH MOORE
DIRECT LINE (416) 868-3427
OUR REF: 020683-001

May 28, 1987.

Mr. K.D. Butler,
Executive Vice-President,
Canadian Dental Service
Plans Inc.,
Suite 600,
2 Lansing Square,
Willowdale, Ontario,
M2J 4Z3.

Dear Kingsley:

Surplus Distribution

You have asked us to respond to a number of questions dealing with issues relating to the distribution of the Surplus Fund of the CDIP life insurance plan. Our responses to these questions supplement the information provided in our letter dated September 11, 1986, the letter dated September 19, 1986 from the firm of Blake, Cassels & Graydon to Towers, Perrin, Forster & Crosby and the memorandum dated July 29, 1985 dealing with the tax consequences of various forms of distribution of the Surplus Fund prepared by our firm. Our responses to the five questions are based on our assumption, as set out in our letter of September 11, 1986 that the CDA stands in a fiduciary relationship to the plan participants in respect of the Surplus Fund. As we have indicated in the past we have been unable to find any reported cases or statutory provisions specifically dealing with surplus distributions of the type in question or the relevant issues. In preparing these responses we have therefore relied on general trust law principles and the few reported cases we have been able to find in which the courts have dealt with somewhat analogous issues.

Questions 1, 3 and 4

Three of the questions deal with the issue of whether the obligations of the Executive Council of the CDA, as Trustee of the Surplus Fund, differ with respect to the two components of the fund, the first being the Underwriting Surplus (the

Mr. K.D. Butler.

portion of the Surplus Fund which results from the experience of the plan being more favourable than actuarial predictions) and the investment surplus (the portion of the Surplus Fund comprised of the interest on the various funds which the insurer is required by the Master Agreement to maintain and the interest on the Cash Flow of the plan).

We have been unable to find any basis for distinguishing between the components of the Surplus Fund, either with respect to whether the Surplus Fund should be distributed or with respect to the manner in which it should be distributed. The basic principle that the CDA Executive Council, as a fiduciary, has an obligation to exercise its discretion with respect to the Surplus Fund in good faith and for the benefit of those whose premium payments led to the creation of the surplus and to avoid favouring some of the beneficiaries at the expense of others applies, in our view, to the Surplus Fund as a whole and not merely to the Underwriting Surplus component of it. It should be noted that no distinction was made in any of the cases dealing with pension fund surpluses which were referred to in our letter dated September 11, 1986 among the various components of the surplus funds being considered in those cases although large portions of those surpluses clearly arose as a result of the investment of the pension fund contributions.

Question 2

The second question asked whether the Executive Council of the CDA, as the Trustee of the Surplus Fund, is responsible "to distribute" the surplus or "for the distribution" of the surplus. In our view the Executive Council is responsible for all aspects of the surplus distribution. CDSPI, acting as the CDA Council on Insurance and Investment, can and should make recommendations to the Executive Council concerning the time and manner of distributing the surplus. The Executive Council, however, has the ultimate responsibility for accepting or rejecting these recommendations and for carrying out the distribution. Under the administration agreement CDSPI can be authorized by the CDA and the insurer to perform the administrative functions involved in the distribution but the decision-making must be done by the CDA rather than by CDSPI.

Question 5

The final question requested that we confirm the conclusions arrived at by our firm in our memorandum dated July 29, 1985 and by Blake, Cassels & Graydon in its opinion dated July 29, 1985 concerning the impact on the status of the CDA and CDSPI, as non-profit corporations, of certain proposals for distributing the Surplus Fund.

May 28, 1986.

Mr. K.D. Butler.

The concerns as to the endangering of the status of the CDA as a "non-profit" organization" as defined in paragraph 149(1)(1) of the Income Tax Act (Canada) only arise if the CDA can be found to beneficially own the funds in the Surplus Fund. Since it is our view that those funds are beneficially owned by the plan participants and that the CDA is a trustee of the funds and not the beneficial owner we can confirm the conclusion set out in our July 29, 1985 memorandum that the distribution by the CDA of all or a portion of the Surplus Fund to plan participants who may be members of the CDA should not endanger the CDA's status as a "non-profit organization". CDSPI's non-profit status should also not be endangered since it at no time acquires any beneficial interest in the Surplus Fund. Since the members of CDSPI are the provincial associations CDSPI's status could only be at risk if it were to acquire a beneficial interest in the Surplus Fund and distribute some portion of it to those associations. Such a distribution is not, as far as we are aware, a possibility which the CDA has ever seriously considered.

Surplus Distribution

With respect to any proposed distribution of the Surplus Fund we must reiterate that the only way in which the CDA can fully protect itself from the risk of a plan participant or a provincial association, on behalf of its members who are plan participants, challenging a distribution is by applying to the court for advice and directions as to the manner in which the surplus should be distributed. In the absence of such an application there will always be some risk that the CDA could be found by a court to have acted in breach of trust with respect to those funds which it distributes and be required to compensate those who have suffered loss as a result of the breach. While the extent of this risk is very difficult to quantify the compensable amount could potentially be the entire amount found to have been improperly distributed.

Yours truly,

CAMPBELL, GODFREY & LEWTAS



A.B. Moore

ABM:JM

AMENDING AGREEMENT

This agreement made this 30th day of September, 1987 between the CANADIAN DENTAL ASSOCIATION ("CDA") and the (the "Co-Sponsor").

WHEREAS:

- A. By an agreement made as of January 1, 1987 between CDA and the Co-Sponsor (the "1987 Participation Agreement") the Co-Sponsor agreed to continue to participate in the sponsorship of the insurance plans and programs sponsored by CDA on the terms and conditions set out in the 1987 Participation Agreement; and
- B. This agreement is being entered into for the purpose of amending certain provisions of the 1987 Participation Agreement.

NOW THEREFORE THIS AGREEMENT WITNESSETH that in consideration of the covenants and agreements herein contained the parties covenant and agree as follows:

- 1. Section 1 of the 1987 Participation Agreements is hereby amended:
 - (i) by the insertion of the following as paragraph (a) thereof:

"Benefit Plans" means, collectively, the Basic Life Insurance, Dependents' Life Insurance, Accidental Death and Dismemberment Insurance, Long Term Disability Insurance

(ii) and Office Overhead Expense Insurance Plans listed in Schedule A;"; and by changing the designations of each of the paragraphs set out in Section 1 from (a) to (i) inclusive to (b) to (j) inclusive.

2. Section 9 of the 1987 Participation Agreement is hereby deleted and the following provision substituted therefor:

"9. In directing and controlling the administration of the Plans, CDA, through its Executive Council, shall adopt the policy (i) of making use of surpluses arising under any Benefit Plan for the benefit of the Benefit Plans or any one or more of them and the Participants therein, and (ii) of making use of surpluses arising under any Plan other than a Benefit Plan for the benefit of such Plan and the Participants therein, through the reduction of premiums, the improvement or addition of benefits, the payment of dividends or otherwise."

3. The 1987 Participation Agreement, as amended by this agreement, is hereby confirmed.

4. This agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

IN WITNESS WHEREOF the parties hereto have duly executed this agreement.

CANADIAN DENTAL ASSOCIATION

By: _____

Date: _____

By: _____

Date: _____

Appendix C

CDA RSP GROWTH

MONTH: APRIL 1987

PLAN YEAR 1987

	\$ Current Month	\$ Year-to-Date 1987	\$ Year-to-Date 1986	% Increase (Decrease)
NEW ACCOUNTS	40	78	59	32%
<u>CONTRIBUTIONS:</u>				
Fixed Income	383,989.00	628,724.21	566,916.70	11%
Common Stock	757,655.68	1,530,626.63	760,807.96	101%
Money Market	284,208.24	578,097.60	283,321.85	104%
Balanced Fund	686,814.79	1,422,084.89	551,143.34	158%
Sub-Total	2,112,667.79	4,159,533.33	2,162,189.85	92%
Guaranteed Fund				
1-Year	48,554.53	95,616.92	24,175.77	295%
2-Year	3,000.00	3,000.00	2,471.96	21%
3-Year	19,015.99	19,015.99	31,084.98	(39)%
4-Year	--	--	--	%
5-Year	11,068.27	17,139.53	23,789.33	(28)%
Sub-Total	81,638.79	134,772.44	81,522.04	65%
TOTAL CONTRIBUTIONS (includes Transfers-in)	2,194,306.58	4,294,305.77	2,243,711.89	91%
<u>TRANSFERS-IN:</u>				
Number of Transfers	156	316	206	54%
Amount \$	1,913,343.10	3,838,798.62	2,095,840.50	84%
NET CONTRIBUTIONS	280,963.48	455,507.15	147,871.39	208%
<u>DE-REGISTRATIONS:</u>				
Number of Accounts	7	17	27	(37)%
Amount \$	112,678.68	268,141.61	759,561.34	(65)%
<u>NET GAIN (LOSS):</u>				
Number of Accounts	33	61	32	90%
Amount \$	2,081,627.90	4,026,164.16	1,484,250.55	172%
TOTAL # OF ACCOUNTS		2,699	1,797	50%
Comments: New accounts: 40 (20 dentists, 3 employees, 1 Hygienist, 1 dental assistant, Spouses - 15. Regional: B.C. - 6, Alta. - 3, Sask. - 1, Man. - 1, Ont. - 20, Que. - 2, Nova Scotia - 2, P.E.I. - 3, NFLD - 3				

*NUMBER OF LICENSED DENTISTS

<u>PROVINCE</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
NFLD. & LAB.	123	134	127	126	127	136	151
NOVA SCOTIA	344	368	314	314	342	339	356
P.E.I.	51	50	41	42	41	43	45
N. BRUNSWICK	193	203	183	194	198	196	240
QUÉBEC	2,510	2,738	2,789	2,789	2,772	2,857	2,750
ONTARIO	4,636	4,873	4,715	4,763	4,947	5,056	5,185
MANITOBA	478	510	439	447	438	474	474
SASKATCHEWAN	328	342	335	333	348	356	360
ALBERTA	1,059	1,107	1,128	1,159	1,194	1,234	1,227
B. COLUMBIA	1,738	1,801	1,757	1,766	1,784	1,873	1,769
NWT-YUK-SUN.	26	27	28	28	30	25	27
TOTAL	11,486	12,153	11,856	11,961	12,221	12,589	12,584

PROVINCIAL PERCENTAGE

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>**Population</u>
NFLD. & LAB.	1.1	1.1	1.1	1.1	1.0	1.1	1.2	2.3
NOVA SCOTIA	3.0	3.0	2.7	2.6	2.8	2.7	2.8	3.4
P.E.I.	0.4	0.4	0.3	0.4	0.3	0.3	0.4	0.5
N. BRUNSWICK	1.7	1.7	1.5	1.6	1.6	1.6	1.9	2.8
QUÉBEC	21.8	22.5	23.5	23.3	22.7	22.7	21.9	25.8
ONTARIO	40.4	40.2	39.8	39.8	40.5	40.2	41.2	36.0
MANITOBA	4.2	4.2	3.7	3.7	3.6	3.8	3.8	4.2
SASKATCHEWAN	2.9	2.8	2.8	2.8	2.8	2.8	2.9	4.0
ALBERTA	9.2	9.1	9.5	9.7	9.8	9.8	9.7	9.3
B. COLUMBIA	15.1	14.8	14.8	14.8	14.6	14.8	14.0	11.4
NWT-YUK-SUN.	0.2	0.2	0.3	0.2	0.3	0.2	0.2	0.3

*Source - Canadian Dental Association

**Source - Statistics Canada July 1986

TOTAL GROSS PREMIUMS AND PARTICIPATION

ALL PARTICIPANTS

<u>Province</u>	<u>1985</u>		<u>1986</u>		<u>1986</u>
	<u>Premium</u>	<u>Participation</u>	<u>Premium</u>	<u>Participation</u>	<u>1985</u> <u>Percentage</u> <u>Increase</u>
NFLD. & LAB.	\$ 209,751	1.6	\$ 236,448	1.6	12.7%
NOVA SCOTIA	433,653	3.3	533,018	3.5	22.9%
P.E.I.	71,911	0.5	80,170	0.5	11.5%
N. BRUNSWICK	310,629	2.4	359,056	2.4	15.6%
QUÉBEC	2,743,118	21.0	3,391,278	22.4	22.4%
ONTARIO	4,808,233	36.7	5,255,893	34.6	9.3%
ITTOBA	504,077	3.9	619,719	4.1	22.9%
SASKATCHEWAN	371,967	2.8	446,348	2.8	20.0%
ALBERTA	1,329,281	10.2	1,573,333	10.4	18.4%
B. COLUMBIA	2,251,035	17.2	2,620,060	17.3	16.4%
NWT-YUK-SUN.	<u>50,191</u>	<u>0.4</u>	<u>57,306</u>	<u>0.4</u>	<u>14.2%</u>
	\$13,083,847	100.0	\$15,172,628	100.0	16.0%

AVERAGE COVERAGE BY PROVINCE

Province	Life*		Dep. Life*		L.T.D.		Off. Ovhd.		A.D. & D.*	
	1985	1986	1985	1986	1985	1986	1985	1986	1985	1986
NFLD. & LAB.	200	212	53	54	2,783	2,934	2,792	2,849	98	112
NOVA SCOTIA	156	160	48	58	2,126	2,401	2,754	2,874	84	101
P.E.I.	185	194	50	58	3,093	3,124	3,329	3,450	106	138
N. BRUNSWICK	165	172	52	57	2,417	2,692	2,676	2,934	92	106
QUÉBEC	135	141	43	50	2,198	2,396	2,635	2,831	79	92
ONTARIO	165	178	49	59	2,322	2,513	2,891	3,140	78	91
MANITOBA	136	150	55	68	2,036	2,358	2,806	3,065	69	84
SASKATCHEWAN	146	158	54	67	2,220	2,468	3,125	3,592	89	114
ALBERTA	149	157	52	61	2,130	2,311	3,207	3,449	81	96
B. COLUMBIA	160	166	56	63	2,367	2,530	3,162	3,382	83	96
NWT-YUK-SUN.	<u>125</u>	<u>129</u>	<u>57</u>	<u>67</u>	<u>1,985</u>	<u>2,125</u>	<u>3,233</u>	<u>5,160</u>	<u>79</u>	<u>70</u>
TOTAL	156	164	50	58	2,275	2,471	3,894	3,128	81	94

	Off. Cont.*		Prac. Int.*		Gen. Lia.*		Mal. Lia.*	
	1985	1986	1985	1986	1985	1986	1985	1986
NFLD. & LAB.	64	75	46	55	1,062	1,115	1,165	1,225
NOVA SCOTIA	66	76	49	53	1,080	1,231	1,153	1,216
P.E.I.	78	90	52	60	1,074	1,214	1,162	1,216
N. BRUNSWICK	78	87	53	55	1,101	1,228	1,120	1,129
QUÉBEC	87	101	58	66	1,059	1,211	1,212	1,109
ONTARIO	108	124	61	68	1,105	1,246	1,060	1,095
MANITOBA	112	126	64	74	1,057	1,241	1,178	1,219
SASKATCHEWAN	88	106	50	53	1,071	1,167	1,143	1,194
ALBERTA	114	138	66	75	1,120	1,263	1,155	1,198
B. COLUMBIA	107	123	62	67	1,102	1,226	1,147	1,184
NWT-YUK-SUN.	<u>69</u>	<u>98</u>	<u>53</u>	<u>55</u>	<u>1,000</u>	<u>1,000</u>	<u>1,065</u>	<u>1,177</u>
TOTAL	102	118	60	67	1,091	1,232	1,139	1,200

*Dollars in thousands

ALL PROVINCES

DENTISTS ONLY

1986 SUMMARY

No. of Eligible Dentists - 12,584

	Total Premium \$	Provincial Participation %	No. of Claims \$	% of Net Premium %	No. of Lives	Penetration %	Average Coverage \$
BASIC LIFE	2,434,110	--	19	103.5	8,565	68	164,000
DEP. LIFE	187,738	--	7	165.4	2,329	--	58,000
L.T.D.	4,578,498	--	440	86.3	7,064	56	2,471
OFF. OVHD.	1,945,926	--	260	75.8	5,015	40	3,128
A.D. & D.	435,425	--	2	58.6	6,312	50	94,000
OFF. CONT.	1,357,607	--	243	58.6	4,236	34	118,000
PRAC. INT.	462,861	--	64	43.6	3,334	26	67,000
GEN. LIAB.	455,361	--	62	30.1	5,969	47	1,232,000
MAL. LIAB.	3,093,486	--	290	78.1	7,131	96*	1,200,000
TOTAL	14,951,012	--	1,387	80.7	13,234		

*Adjusted to exclude Ontario

1985 SUMMARY

No. of Eligible Dentists - 12,589

	Total Premium \$	Provincial Participation %	No. of Claims	% of Net Premium %	No. of Lives Cert's	Penetration %	Average Coverage \$
BASIC LIFE	2,234,250	--	15	57.0	8,236	65	146,000
DEP. LIFE	171,474	--	5	33.5	2,174	--	50,000
L.T.D.	4,213,529	--	417	79.7	6,849	54	2,275
OFF. OVHD.	1,800,081	--	234	64.5	5,084	40	2,894
A.D. & D.	370,792	--	3	95.3	5,975	48	81,000
OFF. CONT.	1,299,268	--	244	50.7	4,154	33	102,000
PRAC. INT.	422,878	--	66	48.9	3,200	25	60,000
GEN. LIAB.	430,808	--	92	46.1	6,186	49	1,091,000
MAL. LIAB.	1,948,257	--	238	109.1	5,950	79*	1,139,000
TOTAL	12,891,337	--	1,314	74.0			

*Adjusted to exclude Ontario

GRADUATES
PARTICIPATION BY FACULTY
1986

	Applications Received	Total Grads	Participation %
DALHOUSIE	34	34	100.0
LAVAL	36	36	100.0
U. OF MONTRÉAL	75	76	99.0
McGILL	35	37	95.0
U. OF TORONTO	89	111	80.0
U. OF WESTERN ONTARIO	54	54	100.0
U. OF MANITOBA	21	22	95.0
U. OF SASKATCHEWAN	22	22	100.0
U. OF ALBERTA	47	47	100.0
U. OF BRITISH COLUMBIA	<u>34</u>	<u>34</u>	<u>100.0</u>
	<u>447</u>	<u>474</u>	<u>94.3</u>

	1985			1984	1983
	Applications Received	Total Grads	Participation %	Participation %	Participation %
DALHOUSIE	28	32	88.0	94.0	100.0
LAVAL	29	29	100.0	100.0	100.0
U. OF MONTRÉAL	72	73	99.0	98.0	90.0
McGILL	35	39	90.0	86.0	73.0
U. OF TORONTO	92	120	77.0	83.0	84.0
U. OF WESTERN ONTARIO	56	56	100.0	98.0	94.0
U. OF MANITOBA	24	24	100.0	95.5	94.0
U. OF SASKATCHEWAN	21	21	100.0	100.0	100.0
U. OF ALBERTA	40	40	100.0	100.0	100.0
U. OF BRITISH COLUMBIA	<u>38</u>	<u>38</u>	<u>100.0</u>	<u>100.0</u>	<u>83.0</u>
	<u>435</u>	<u>472</u>	<u>92.0</u>	<u>95.0</u>	<u>90.0</u>

COUNCIL ON NOMINATIONS, AWARDS AND TRUSTS

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. P.R. Crawford - Acting Chairman, Winnipeg
 Dr. W.R. Thompson, Trenton
 Dr. B.W. Holmes, Kenora
 Dr. R.N. Hicks, West Vancouver

ITEMS REQUIRING BOARD ACTION

1. Council did not meet during the term; business was conducted by correspondence and telephone.
2. Solicitation of nominations for elective offices and vacancies was conducted in accordance with the by-laws and terms of reference of the Council.
3. All elective offices and vacancies for the 1987-88 term have been filled by eligible nominees.
4. Elections are to be held during the annual meeting of the Board of Governors in Ottawa, Ont., September 11-12, 1987.
5. Elections will be required as indicated in the appended table. APPENDIX I
6. **RESOLVED:**
 87.137 **THAT one ballot be cast to elect those candidates to offices and vacancies where no opposition exists.**

ADOPTED

NOTE: Scrutineers: **Mr. A.J. Neilson, Executive Director, CDA**
 Dr. K.F. Pownall, Royal College of Dental Surgeons of Ontario

Following an election by ballot, the results were:
Dr. Jack Neidermayer, Saskatchewan-Manitoba, President-Elect.

RESOLVED:

- 87.138** **THAT the ballots be destroyed.**

ADOPTED

COUNCIL ON NOMINATIONS, AWARDS AND TRUSTS

7. The call for nominations, the nomination form and the list of nominees with biographical information are appended and comprise part of this report.

RESOLVED:

87.139 THAT Dr. John Robertson fill the vacancy on the Council on Nominations, Awards and Trusts.

ADOPTED

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

8. CDA President's Award

APPENDIX II

A list of the 1986-87 recipients of the CDA President's Award is appended. This Award was granted for the first time this year.

9. Honorary Membership

APPENDIX III

As quoted in the Terms of Reference, Honorary Membership is the highest award of the Association. Its purpose is to recognize individuals deemed to have made outstanding contributions to the art and science of dentistry, or to the dental profession, over a sustained period of time. This award may be for service that is provincial, national or international in nature. It should not be viewed as an automatic award, following a great number of years of practice. Due to the distinctive nature of the Honorary Membership Award, only in the most unusual circumstances will there be more than one award conferred in any one year. An award each year shall not be considered a requirement.

THAT Honorary Membership in CDA be conferred on:

Dr. William R. Thompson
(Nominated by the Council on Nominations, Awards and Trusts)

10. Distinguished Service Award

APPENDIX IV

As indicated in the Terms of Reference, this award may be given to a dentist or other person, in recognition of an outstanding contribution in a given year, or outstanding service over a number of years. It may also recognize outstanding contributions to the dental profession at the corporate level, specialty society, council or committee level. An award each year shall not be considered a requirement.

THAT the Distinguished Service Award be granted to:

Dr. James Douglas McLean
(Nominated by the Nova Scotia Dental Association)

11. Council expresses appreciation to the nominators for their assistance in providing nominees, to the candidates for their willingness to serve and to the staff for their assistance.

Respectfully submitted,

P. Ralph Crawford, D.M.D.
Acting Chairman
Council on Nominations,
Awards and Trusts

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Nominations, Awards and Trusts with appreciation.

*

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
Chairman of the Board Dr. N.A. Mancini (Ont.)	Elected annually	Active or Honorary member	1 year	1. Dr. N.A. Mancini (Ont.)
President-Elect Dr. R.J. Markey (B.C.)	Elected annually	Member of Board of Governors	1 year	1. Dr. J.W. Niedermayer (Sask.) 2. Dr. J.S. Christie (N.S.) 3. Dr. E.F. Allison (Alb.)
Executive Council Dr. E.F. Allison (Alb.) 1987 (1) Dr. J.W. Niedermayer (Sask./Man.) 1987 (2) Dr. G. Dubé (Qué.) 1987	Annual Election to fill expired term	Member of Board of Governors	2 years	1. Dr. Bryn Sigfstead (Alb.) 2. Dr. L.S. Allen (Sask./Man.) 3. Dr. G. Dubé (Qué.)
Constitution & By-Laws Dr. M.J. Crompton (N.B.) 1987 (1) Dr. B.M. Jackson (Ont.) 1987 (2)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. M.J. Crompton (N.B.) 2. Dr. R.R. Schiewe (Ont.)

NOMINATIONS - CDA ELECTIVE OFFICES - 1987

-2-

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
<u>Education and Accreditation</u> Dr. B.S. Graham, UNIV (N.S.) 1987(1) Dr. G.R. Thordarson, REG. (B.C.) 1987(1) Dr. R. Barr, STUDENT (Man.) 1987 Ms. J. Roberts, LAY REP. (Ont) 1987(1) Dr. G.S. Beagrie, RCD(C), (B.C.) 1987(2)	Annual Election to fill expired	CDA Member with stipulations	3 years	1. Dr. Bruce Graham (UNIV) 2. Dr. Jack G. Thompson (REG.) 3. Ms. Madeleine Shildkraut (STUD.) 4. Ms. J. Roberts (LAY REP.) 5. Dr. J.H.P. Main (RCDC)
<u>Ethics</u> Dr. G.G. Turner (N.S.) 1987(1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. Blake Creaser (N.S.)
<u>Health Care</u> Vacant (Qué.)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. Jean Sirois (Qué.)
<u>Hospital and Institutional Services</u> Dr. J. Hardie (Ont.)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. John Hardie (Ont.)

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
Information Services Dr. Y. Kamachi (Ont.) 1987 (2) Dr. T. Koltek (Prairies) 1987 (2) Dr. P. O'Brien (Atl. Prov.) 1987	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. W. Hettenhausen (Ont.) 2. Dr. G.M. Ritson-Bennett (Prairies) 3. Dr. P. O'Brien (Atl.)
				* ELECTION REQUIRED

MEMORANDUM

March 30, 1987

TO: Members of the Board of Governors
Presidents and CEO's - Corporate Members
CDA Council Chairmen
Presidents and Secretaries of Specialty
Sections
ACFD - NDEB - HCD(C) -
Provincial Registrars
Presidents - CDHA - CDAA

FROM: Dr. P. Ralph Crawford, Chairman
Council on Nominations, Awards and Trusts

SUBJECT: CDA NOMINATIONS 1987

1. Elections of officers and council personnel for the 1987-88 term will take place during the 1987 Annual Meeting of the Board of Governors in Ottawa, on September 11-12, 1987.
2. Except in the case of nominations to the Council on Nominations, Awards and Trusts itself, nominations from the floor during the Annual Meeting will not be valid unless vacancies are created by withdrawals from the list of nominations as presented by the Council on Nominations, Awards and Trusts. The Board may then make further nominations from the floor.
3. It is the duty of the Council on Nominations, Awards and Trusts (Article XVI, Section 4 (i), (i-v) to:
 - a) prepare a list of all elective offices to be filled;
 - b) solicit nominations, excluding those for the Council on Nominations, Awards and Trusts;

.../2

- c) rule on eligibility;
 - d) make further nominations as necessary, or as Council sees fit;
 - e) submit a report to the Annual Meeting.
4. Nominations must be received before JUNE 1, 1987.
5. Those entitled to make nominations are:
- Members of the CDA Board of Governors
CDA Council Chairmen
Presidents or Secretaries of Corporate Members
Presidents or Secretaries of Specialty Sections
6. Nominees to the Council on Education will include the recommendations of:
- The Association of Canadian Faculties of Dentistry
The National Dental Examining Board of Canada
The Royal College of Dentists of Canada
The Conference of Provincial Dental Licensing Authorities
Canadian Dental Hygienists' Association
Canadian Dental Assistants' Association
7. All nominations must be accompanied by:
- (a) Written consent of the nominee.
 - (b) A completed conflict of interest statement by the nominee.
- Failure to comply with these two requirements will nullify the nomination.
8. Except for Executive Council (as otherwise indicated), election to Councils is for a term of three years, renewable once. Members of the Councils must be Active, Affiliate, or Student Members of the Canadian Dental Association. Affiliate members are not eligible for nominations for election to the Board of Governors or the Executive Council. Student members are not eligible for nomination for election to the Executive Council.

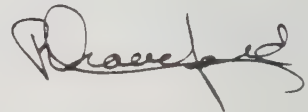
Nominations are not required for the Council on Dental Materials and Devices or the Council on Insurance and Investment for reasons outlined in the following pages.

9. Nominations should be accompanied by a brief biographical sketch of the nominee attached to the nomination form. Please use the form provided limiting your submission to one page. (A sample is included for your information).

PLEASE FORWARD YOUR NOMINATION(S)
WRITTEN CONSENT OF THE NOMINEE'S
WILLINGNESS TO STAND FOR OFFICE
AND A BRIEF BIOGRAPHICAL SKETCH
OF EACH NOMINEE TO:

Dr. P. Ralph Crawford, Chairman
Council on Nominations, Awards and Trusts
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario, K1G 3Y6

DEADLINE: June 1, 1987



c.c.: Members, Council on Nominations, Awards and Trusts

/ml

MEMORANDUM

Le 30 mars 1987

AUX: Membres du Bureau des gouverneurs
Présidents et directeurs généraux des
corporations membres
Présidents des conseils de l'ADC
Présidents et secrétaires des sections
spécialisées
Association des Facultés de médecine dentaire du
Canada
Bureau national d'examen des dentistes du Canada
Collège royal des dentistes du Canada
Registraires provinciaux
Présidents - ACHD - ACAD

DE: Dr. P. Ralph Crawford, président
Conseil des candidatures, des distinctions et
des fondations

OBJET: CANDIDATURES AUX POSTES DE L'ADC POUR 1987-88

-
1. L'élection des dirigeants et des membres des conseils pour l'exercice 1987-1988 se déroulera lors de l'assemblée annuelle du Bureau des gouverneurs qui aura lieu les 11 et 12 septembre 1987, à Ottawa.
 2. Sauf pour les nominations au Conseil des candidatures, des distinctions et des fondations lui-même, aucune candidature ne peut être présentée directement au cours de l'assemblée annuelle, à moins qu'il s'agisse de combler une vacance créée par le retrait d'un candidat qui avait été inscrit sur la liste du Comité des candidatures, des distinctions et des fondations. Le Bureau acceptera alors les candidatures mises de l'avant par les participants.

.../2

3. Il incombe au Conseil des candidatures, des distinctions et des fondations (Article XVI, alinéa 4(i) (i-v):
 - a) de préparer la liste de tous les postes électifs à combler;
 - b) de solliciter les candidatures, sauf au Conseil des candidatures, des distinctions et des fondations;
 - c) de décider de l'éligibilité des candidats;
 - d) d'appeler d'autres candidats, au besoin ou s'il juge opportun de le faire;
 - e) de faire rapport à l'assemblée annuelle.
4. Les candidatures doivent être reçues avant le 1ER JUIN 1987.
5. Ont le droit de présenter des candidats:
 - les membres du Bureau des gouverneurs de l'ADC,
 - les présidents des conseils de l'ADC,
 - les présidents ou secrétaires des corporations membres,
 - les présidents ou secrétaires des sections spécialisées.
6. Les candidatures au Conseil de l'éducation doivent être recommandées par:
 - l'Association des Facultés de médecine dentaire du Canada,
 - le Bureau national d'examen des dentistes du Canada,
 - le Collège royal des dentistes du Canada,
 - la Conférence des organismes de réglementation provinciaux,
 - l'Association canadienne des hygiénistes dentaires,
 - l'Association canadienne des assistantes dentaires.
7. Toute candidature doit être assortie des documents suivants:
 - a) l'acceptation par écrit du candidat;
 - b) la déclaration du candidat concernant le conflit d'intérêt.

Le manquement à ces deux conditions entraîne l'annulation de la candidature.

8. Sauf pour le Conseil exécutif (et à moins d'indication contraire), les membres des conseils sont élus pour un mandat de trois ans, renouvelable une seule fois. Ils doivent être membres actifs, affiliés ou étudiants de l'Association dentaire canadienne. Les membres affiliés ne sont pas éligibles au Bureau des gouverneurs, ni au Conseil exécutif. Les membres étudiants ne sont pas éligibles au Conseil exécutif.

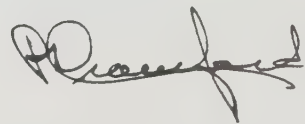
Aucune candidature n'est requise pour le Conseil des matériaux et appareils dentaires ou pour le Conseil des assurances et des placements pour les raisons indiquées dans les pages qui suivent.

9. Il faut joindre au formulaire de mise en candidature une brève note biographique du candidat.

Veuillez envoyer votre ou vos candidatures,
l'acceptation par écrit,
la déclaration sur le conflit d'intérêt
et la note biographique de chaque candidat au:

Dr. P. Ralph Crawford, président
Conseil des candidatures, des distinctions et des fondations
Association dentaire canadienne
1815, Promenade Alta Vista
Ottawa (Ontario)
K1G 3Y6

AVANT LE 1ER JUIN 1987



/ml

NOMINATION FORM - CDA

One form must be completed for each candidate. Candidates must be eligible to assume office if elected (see conflict of interest by-law on reverse of this form, and specific regional or other stipulations for nominations on the attached memorandum).

PLEASE CHECK OR COMPLETE ONE OF THE FOLLOWING:

Nomination for: Chairman of the Board _____
 President-Elect _____
 Executive Council _____
 Council on _____

* NOTE: Affiliated members are not eligible for nomination to the Board of Governors or Executive Council.
 Student members are not eligible for nominations to the Executive Council.

PLEASE PRINT OR TYPE THE FOLLOWING:

Candidate's Name _____

Candidate's Address _____

Postal Code _____

It is desirable for a nominee to attach a brief biographical sketch if possible.

IN ACCORDANCE WITH THE STIPULATIONS OF THE CONSTITUTION AS TO REGIONAL OR OTHER REPRESENTATION, AND, AS TO MY ENTITLEMENT TO MAKE NOMINATIONS, I PROPOSE THE ABOVE CANDIDATE FOR NOMINATION.

PLEASE PRINT OR TYPE THE FOLLOWING:

Nominator _____ Office/Position _____

Signature _____

**NOTE: Please notify the candidate's provincial association identifying the candidate and the office, council or committee to which he/she has been nominated.

ACCORDING TO ARTICLE XXI SECTION 1 OF THE CONSTITUTION, THE FOLLOWING APPLIES:

- a) Every member of the Board of Governors of the Association who has directly or indirectly any interest in any contract or transaction or in any business or undertaking which provides dental supplies or services of any kind to the dental profession, shall declare his material interest in the foregoing. He then will absent himself from discussion and voting on such contract or transaction.
- b) If a Governor has made a declaration in compliance with the above provisions and he has not voted in respect of the contract or transaction, and if he has acted honestly and in good faith, he is not accountable to the Association for any profit or gain realized and the contract or transaction is not voided.
- c) The above provisions apply automatically to the members of the various Committees, and Councils of the Association, including the Executive Council. Each Board and/or Council or Committee member in order to make sufficient disclosure, is required to do so not only to his Council, etc., members but also to the Board of Governors in writing.
- d) All nominees for election or appointment to Councils or Committees of the Association, including the Executive Council shall declare on the nomination form, all possible potential conflicts of interest. These shall be made known to the Board prior to the election.
- e) That, of itself, being a Trustee of the CDA administered insurance and investment plans and/or of itself being a representative of the CDA to the Board of Canadian Dental Service Plans Incorporated shall not constitute a potential conflict of interest for a current member or a candidate for election to the Executive Council of the CDA.
- f) A conflict of interest shall exist where a member of the Board of the CDA or any of its Councils and Committees is privy to information that could be construed to be confidential and of benefit to that individual or any organization with which he may be associated. In such situations such a member shall be required to give an undertaking that such information be kept confidential.

ARTICLE XXI SECTION 1 OF THE CONSTITUTION APPEARS ON THE REVERSE OF THIS NOMINATION FORM. THIS ARTICLE DEALS WITH POSSIBLE POTENTIAL CONFLICTS OF INTEREST.

NOMINEE WILL PLEASE INITIAL ONE OF THE FOLLOWING:

- A) I have no known possible potential conflict of interest _____
- b) I have a possible conflict of interest _____
if b) please explain potential conflict on the reverse of this form.

I agree to permit my nomination and qualify by Active ___ Affiliate ___
Student ___ Membership in the CDA

Membership in _____ (Corporate Member)

NAME OF ORGANIZATION RECOMMENDING THIS NOMINATION _____

SIGNATURE OF NOMINEE _____

- 4 -

- g) The Board shall be the final authority on any disputed conflict of interest.

PLEASE INDICATE BELOW ANY POSSIBLE POTENTIAL CONFLICT OF INTEREST:

Return this completed form by JUNE 1, 1987 to:

Dr. P. Ralph Crawford, Chairman
Council on Nominations, Awards and Trusts
Canadian Dental Association, 1815 Alta Vista Dr.
OTTAWA, Ontario, K1G 3Y6

BIOGRAPHICAL INFORMATION

NAME:

ADDRESS:

DATE AND PLACE OF BIRTH:

POSITION/PRACTISE:

EDUCATION:

DEGREES:

EXPERIENCE:

ORGANIZATIONS:

OTHER:

AWARDS:

SAMPLE

BIOGRAPHICAL INFORMATION

NAME: John Doe Dentist

ADDRESS: 123 Molar Street, Toronto, Ontario

DATE AND PLACE OF BIRTH:

POSITION/PRACTISE: Private Practice: Specialty limited to Orthodontics

EDUCATION: High School(s) and University(s)

Hamilton High
University of Western Ontario
University of Toronto - Post Graduate Studies (Orthodontics)

DEGREES: (with dates)
D.D.S. (Western Ontario 1967)
Diploma in Orthodontics - (Toronto, 1972)

EXPERIENCE: Including previous appointments, Military Service, Publications, Research Projects, etc.

General Practice - 1967-1970 - Hamilton
Specialty Practice - Orthodontics, 1970-1986 - Toronto
Past-President - Toronto Dental Society 1980-1982
Board Member ODA - 1981-1986
Chairman, Economics Committee - ODA
Member Council Education, CDA 1985 Published 3 papers
Contribution to Text Book, "Ortho in '80's"

ORGANIZATIONS: Association or Club Membership

Ontario Dental Association
Canadian Dental Association
Toronto Orthodontic Club
American Academy Orthodontics
Alpha Beta Gamma
F.I.C.D;
F.R.C.D. (c)
F.A.R.E.

OTHER: 1973-1979: Part-time demonstrator - Ortho - University of Toronto
1979-1986: Part-time Lecturer - Ortho - University of Toronto

AWARDS: Military, Academic, etc.

NOMINATIONS
1987

I. President-Elect

Term: 1 year
Eligibility: Member of the Board of Governors

1. _____

II. Chairman of the Board

Term: Elected annually
Eligibility: Active or Honorary Member (may hold no other elective office during his tenure as Chairman)

Incumbent: N.A. Mancini, Hamilton
Eligible for re-election

1. _____

III. Executive Council - 9 members

Term: 2 years: renewable twice
Eligibility: Member of the Board of Governors

Incumbents: B.W. Holmes, Past-President
J.R. Robertson, President
R.J. Markey, President-Elect
G. Dubé, Quebec, 1987
E.F. Allison, Alberta, 1987 (1)
J. Christie, Nova Scotia, 1988 (1)
J.W. Niedermayer, Saskatchewan, 1987 (2)
D.E. MacFarlane, Vancouver, 1988 (1)
K.L. Roach, Pembroke, 1988 (1)

Summary:

The Executive Council shall consist of the President, Immediate Past-President, President-Elect and six additional members. The President-Elect and six additional members shall be elected by the Board of Governors from its membership. The province from which a member is licensed at the date of the Annual Meeting shall determine the province from which the candidate has been drawn. The six additional members shall consist of one each from the following regions:

- (a) Province of British Columbia
- (b) Province of Alberta
- (c) Provinces of Saskatchewan - Manitoba
- (d) Province of Ontario
- (e) Province of Quebec
- (f) Provinces of New Brunswick, Nova Scotia, P.E.I. and Newfoundland

Dr. B.W. Holmes is retiring as Past-President. Dr. E.F. Allison is completing his first term on Executive Council and will complete his third consecutive term of 2 years as a member of the Board of Governors at the 1987 Annual Meeting. A nomination is required. Dr. J.W. Niedermayer is completing his second term on Executive Council and will complete his third consecutive term of two (2) years as a member of the Board of Governors at the 1987 Annual Meeting. A nomination is required.

Dr. G. Dubé is a presidential appointment to replace Dr. J.C. Giguère. Dr. Giguère's term would have ended in 1987. Dr. Dubé is eligible for election.

If an incumbent in his non-elective year is elected President-Elect, the uncompleted term will be filled by presidential appointment.

- 3 to be elected 1. _____ Quebec
 2. _____ Alberta
 3. _____ Sask./Manitoba

IV. Council on Constitution & By-Laws: 4 members

Term: 3 years: renewable once

Incumbents: G.H. Peacock, Saskatoon, 1988 (2), Chairman
B.M. Jackson, Kitchener, 1987 (2)
M.J.R. Leitch, British Columbia, 1989 (2)
M.J. Cripton, New-Brunswick, 1987 (1)

Summary

Dr. M.J. Cripton is completing his first term and is eligible for re-election.

Dr. B.M. Jackson is completing his second term and a nomination is required to fill this vacancy.

- 2 to be elected 1. _____
2. _____

V. Council on Dental Materials and Devices: 8 persons

Term: Nominated by the Executive Council and appointed by the Board of Governors annually.

Incumbents: R.Y. Barolet, Ste-Foy, Chairman
P.C. Desautels, Montreal
L.N. Johnson, London
D.W. Jones, Halifax
D. Smith, Toronto
P.T. Williams, Winnipeg
R. Roydhouse, Vancouver

VI Council on Education and Accreditation: 17 members

Term: 3 years: renewable once

Incumbents:	A. Schwartz, Winnipeg, 1989 (2), Chairman	UNIV
	M.A. Boyd, Vancouver, 1988 (2)	UNIV
	B.S. Graham, Halifax, 1987 (1)	UNIV
	I. Vogan, Halifax, 1988 (1)	NON-UNIV
	G.W. Burgman, Kirkland Lake, 1988 (2)	NON-UNIV
	M. Jahjah, Montreal, 1988 (2)	NON-UNIV
	E.W. McIntyre, Edmonton, 1988 (2)	NON-UNIV
	G. Thompson, Edmonton, 1988 (1)	ACFD
	G.S. Beagrie, Edmonton, 1987 (2)	RCD(C)
	K.F. Pownall, Toronto, 1988 (2)	REGISTRAR
	G.R. Thordarson, Vancouver, 1987 (1)	REGISTRAR
	H.M. Dick, Edmonton, 1988 (1)	NDEB
	A.F. Labounty, Kelowna, 1989 (1)	NDEB
	R. Barr, Winnipeg, 1987	STUDENT
	(1 year: renewable annually)	
	J. Robarts, Toronto, 1987 (1)	LAY REP.
	K. MacDonald, Halifax, 1988 (1)	CDHA
	M. Paquin, Vancouver, 1988 (1)	CDA

Summary:

Dr. B.S. Graham and G.R. Thordarson are completing their first terms and nominees are required for UNIV and REGISTRAR representatives respectively.

Dr. R. Barr is completing a one-year term and a nomination is required for a STUDENT representative.

Ms. J. Robarts is completing her first term as LAY REP. and is eligible for re-election

Dr. G.S. Beagrie is completing his second term and a nomination for the RCD(C) representative is required.

Dr. I. Vogan has recently resigned from Council and a presidential appointment will be made to fill this vacancy. (Article XI - Section 2 (g)).

5 to be elected

1. _____ UNIV
2. _____ REGISTRAR
3. _____ STUDENT
4. _____ RCD(C)
5. _____ LAY REP.

VII. Council on Ethics: 5 members

Term: 3 years: renewable once

Incumbents: G.R. Thordarson, Vancouver
(Interim Appointment), Chairman
M.A. Lasko, Winnipeg, 1989 (2)
W.G. Leggett, Ontario, 1988 (2)
G.G. Turner, Glace Bay, 1987 (1)
B.G. Saik, Calgary, 1988 (1)
B.N. Rocky, Richmond, 1989 (1)

Summary :

Dr. G.R. Thordarson has been appointed by the President as Interim Chairman.

Dr. G.G. Turner is completing his first term and is eligible for re-election.

1 to be elected 1. _____

VIII. Council on Health Care: 14 members

Term: 3 years: renewable once

Incumbents: A. Toeman, Quebec, 1988 (2), Chairman
D.G. Sage, Ontario, 1989 (2)
G. McFarlane, Newfoundland, 1989 (2)
R.B. Porter, Nova Scotia, 1989 (2)
W. Allen, P.E.I., 1988 (1)
T.D. Fantin, British Columbia, 1988 (1)
K.I. Hamilton, Saskatchewan, 1988 (2)
D.E. Upton, Alberta, 1988 (1)
L-Col. P.R. McQueen, Ontario, CFDS, 1988 (2)
J.C. Rooney, New Brunswick, 1988 (1)
K.R. Skinner, Manitoba, 1988 (2)
P. Lader, Halifax, 1988 (1)
S. Mader, Seattle, 1988 (1)
Vacant, (Quebec)

Summary

The position of Quebec representative has been vacant since Dr. Toeman was appointed Chairman in 1986 and a nomination is required for the Quebec representative.

1 to be elected 1. _____ Quebec

IX. Council on Hospital and Institutional Services: 6 members

Term: 3 years: renewable once

Incumbents: J. Gryfe, Weston, 1987 (2), Chairman
 C. Foster, Winnipeg, 1989 (2)
 J. Hardie, Ottawa
 E.L. MacInnis, Halifax, 1989 (2)
 J.V. Legault, Montreal, 1989 (1)
 W.S. Walter, Vancouver, 1989 (2)

Summary

The Council on Hospital Services shall consist of five members representative of the Atlantic Provinces, Quebec, Ontario, the Prairie Provinces and British Columbia.

Following selection by the Executive Council of the Chairman of the Council on Hospital and Institutional Services, the CDA President in consultation with the corporate body or region of corporate bodies from which the Chairman is selected is authorized to appoint another representative from that Province or region to fill the vacancy created on the Council.

Dr. J. Gryfe is completing his second term and is not eligible for re-election.

J. Hardie is filling the vacancy of the chairman for 1986-1987, and is eligible for election.

1 to be elected 1. _____ Ontario

X. Council on Information Services: 5 members

Term: 3 years: renewable once

Incumbents: Y. Kamachi, Ontario, 1987 (2), Chairman
 T. Koltek, Prairie Provinces, 1987 (2)
 P. O'Brien, Atlantic Provinces, 1987
 R. Howaniec, British Columbia, 1989 (2)
 G. Lafrenière, Quebec, 1989 (2)

Summary

The Council on Information Services shall consist of five members representative of the Atlantic Provinces, Quebec, Ontario, the Prairie Provinces and British Columbia.

Drs. Y. Kamachi and T. Koltek are completing their second terms and are not eligible for re-election. Nominations are required to fill these vacancies.

Dr. C. Leblanc resigned his position on Council during 1986-87 and Dr. P. O'Brien is filling this vacancy.

- 3 to be elected
1. _____ Ontario
 2. _____ Prairies Prov.
 3. _____ Atl. Prov.

XI. Council on Insurance and Investment

The Canadian Dental Association has delegated to the Canadian Dental Service Plans Inc. the function of the Council on Insurance and Investment as a result of an agreement between the two organizations. This agreement is to be reviewed annually by the Board of Governors of the Canadian Dental Association and the Canadian Dental Services Plans Inc.

None to be elected

XII. Council on Nominations, Awards and Trusts: 3 members plus Past-President as Chairman

Term: 3 years

Incumbents: P.R. Crawford, Manitoba, Chairman, 1989
W.R. Thompson, Ontario, 1987
R.N. Hicks, British Columbia, 1988
B.W. Holmes, Ontario

Summary

The Council on Nominations shall consist of three members elected by the Board at its Annual Meeting, pursuant to Article X, Section 6 of the By-laws, together with the Past-President, who shall be Chairman. The membership should be geographically representative of the Association and shall include one or more Past-Presidents.

- 7 -

Dr. W.R. Thompson is completing his term and nominations will be received from the floor at the Annual Meeting to fill one vacancy.

Dr. P.R. Crawford is a presidential appointment as Chairman.

1987/03/12

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CURRICULUM VITAE

CHAIRMAN OF THE BOARD

Name MANCINI, N.A.

Address 280 Barton Street East, Hamilton, Ontario L8L 2X3

Office Telephone No. 529-0041 Area Code 416

Personal: Married - Josephine, Oct. 10, 1949
3 sons - Michael Gerard, Nicholas Anthony Jr., John Patrick

Education: Elementary - St. Ann's School, Hamilton
Secondary - Cathedral High School, Hamilton
B.A. (Chem., Physics, Biology) University of Toronto
D.D.A. - University of Buffalo

Memberships: Served on original Foundation Committee for the
Hamilton Theatre Auditorium Centre
Served on Hamilton Urban Renewal Committee
Served on Staff of Hamilton Civic Hospitals
Served (6 yrs.) Board of Governors of Hamilton Civic
Hospitals
Served for one year - Board of Directors of Social
Planning and Research Council
Past Chairman of Canadian Catholic School Trustees
Assoc. (C.C.S.T.A.)
Past Chairman of Ontario Separate School Trustees
Assoc. (O.S.S.T.A.)
Presently on Executive Council of O.S.S.T.A..
Past Chairman of Ontario School Trustees Council
(O.S.T.C.) which includes 5 Trustees' Associations of
Ontario)
Presently on Board of Directors of O.S.T.C.
Dominion Council of Health (3 yrs.)
Past Chairman of Hamilton-Wentworth Roman Catholic
Separate School Board
Presently School Trustee and Chairman of Education
Committee
Accorded Papal Honour (made a K.S.6) (Knighthood) Knight
of St. Gregory
Past President of Hamilton Academy of Dentistry
Member - Canadian Academy of Prosthodontists
Serving as Chairman of Board - O.D.A.
Serving as Chairman of Board - C.D.A.
Past Grand Knight - Knights of Columbus, Hamilton

BIOGRAPHICAL INFORMATION

NAME: John William Niedermayer

ADDRESS: 710 - 1805 Rose Street, Regina, Saskatchewan, S4P 1Z8.

DATE AND PLACE OF BIRTH: February 27, 1938, Regina, Saskatchewan.

POSITION/PRACTICE: Private Practice.

EDUCATION: Regina Campion College Jesuit High School
University of Saskatchewan
University of Alberta.

DEGREES: B.A. - University of Saskatchewan, 1960
D.D.S. - University of Alberta, 1964.

EXPERIENCE:

- General Practice - 1964 - Present
- Past President Regina and District Dental Society (1974)
- Past Chairman Economic and Legislation Committees,
College of Dental Surgeons of Saskatchewan
- Past President, College of Dental Surgeons of Saskatchewan (1974)
- Member of Board of Governors of Canadian Dental Association
1981 - Present
- Executive Council Member of Canadian Dental Association,
1982 - Present
- Past member of Canadian Dental Association Committee on
Salaried Dentists
- Past or Present Canadian Dental Association Liaison to
 - (i) Council On Student Affairs
 - (ii) Council on Information Services
 - (iii) Council on Health Care
 - (iv) Council on Hospital and Institutional Services
 - (v) Council on Ethics.

ORGANIZATIONS:

Regina and District Dental Society
College of Dental Surgeons of Saskatchewan
Canadian Dental Association
Regina Pasqua Hospital
F.I.C.D.

AWARDS:

General Proficiency Gold Medal from Campion College.

BIOGRAPHICAL INFORMATION

NAME: DR. JOHN SINCLAIR CHRISTIE

ADDRESS: 1595 Bedford Highway, Bedford, Nova Scotia B4A 1E7

DATE AND PLACE OF BIRTH: April 30, 1945 Halifax, N.S.

POSITION/PRACTISE: Private Practice
Part-time Faculty of Dentistry - Dalhousie - Assistant
Professor

EDUCATION: Queen Elizabeth High School
D.D.S. Dalhousie University

DEGREES: D.D.S. Dalhousie University

EXPERIENCE: ADMISSIONS COMMITTEE, Dalhousie University, Member 1975 - 1978
AD HOC COMMITTEE to advise the Dean on the appointment of a
Chairman for the Dept. of Pediatrics and Community Dentistry
Member - 1978
COMMITTEE TO REVIEW STATUS OF EXPANDED DUTY DENTAL HYGIENE PROGRAM
Member - 1982 to 1983
ALUMNI RELATIONS COMMITTEE - Chairman 1984 - 1986
PART TIME FACULTY ADVISORY COMMITTEE - 1987
ADVISORY COMMITTEE: Epidemiology Position in Dentistry - 1987
TEACHING STAFF, Dental Assistant Program, Nova Scotia Institute
of Technology 1981 - 1985
ADVISORY COMMITTEE - Dental Assistant Program, Nova Scotia
Institute of Technology - 1981 - 1986
CHAIRMAN, DENTAL CARE SYSTEMS COMMITTEE, Nova Scotia Dental
Association 1975 - 1977
EXECUTIVE, NOVA SCOTIA DENTAL ASSOCIATION 1975 - present
PRESIDENT, NOVA SCOTIA DENTAL ASSOCIATION 1978 - 1979
AD HOC COMMITTEE on Concerns and Responsibilities of Dental Bodies
Having Statutory Powers - Canadian Dental Association 1979
CO-CHAIRMAN, CDA NATIONAL CONVENTION COMMITTEE, Halifax, N.S.
1979 - 1980
BOARD OF GOVERNORS, Nova Scotia Member, Canadian Dental
Association 1980 - present
DENTAL ADVISORY COMMITTEE TO NOVA SCOTIA HEALTH INSURANCE COMM.
1982 - present
N.S.D.A. REPRESENTATIVE to N.S. Government Dental Services
Review Commission 1982
MEMBER OF THE WORKING GROUP ON DENTAL HYGIENE, Dept. of Health
and Welfare Canada 1982 - present

- 2 -

EXECUTIVE COUNCIL, Canadian Dental Association 1985 - present

EXECUTIVE & LIASONS - Council on Student Affairs - 1985/86

Council on Materials and Devices - 1985/86

Council on Education and Accreditation - 1986/87

ORGANIZATIONS: HALIFAX COUNTY DENTAL SOCIETY
NOVA SCOTIA DENTAL ASSOCIATION
CANADIAN DENTAL ASSOCIATION
INTERNATIONAL COLLEGE OF DENTISTS
PIERRE FOUCARD ACADEMY
CANADIAN SOCIETY OF FORENSIC SCIENCE

OTHER: ATLANTIC CANADA AVIATION MUSEUM - Past President
HALIFAX CEREBRAL PALSY ASSOCIATION
NOVA SCOTIA RIFLE ASSOCIATION
MARITIME ARMS COLLECTOR ASSOCIATION
DENTAL REPRESENTATIVE (FUND RAISING) - DIABETES ASSOCIATION
DENTAL REPRESENTATIVE (FUND RAISING) - BIG BROTHERS/BIG SISTERS

AWARDS: WIFE - JANE

BIOGRAPHICAL INFORMATION

NAME: DR. EDWARD FRANCIS ALLISON

ADDRESS: 55, 1812 - 4th Street, CALGARY, ALBERTA T2S 1W1

DATE AND PLACE OF BIRTH: May 12, 1929
Calgary, Alberta

POSITION/PRACTISE: Private Practice

EDUCATION: High School - Calgary
University of Alberta

DEGREE: B.Sc. - University of Alberta - 1951
D.D.S. - University of Alberta - 1953

EXPERIENCE: GENERAL PRACTICE - 1953 to present time
DENTAL CORPS, #59 Dental Unit - 1953-61, rank of Major
CALGARY & DISTRICT DENTAL SOCIETY
President - 1963
PACIFIC DENTAL FEDERATION
1st Vice-President - 1966-69
ALBERTA DENTAL ASSOCIATION
Chairman, Council on Auxiliary Services - 1966-72
Member of the Board of Directors - 1971-79
Vice-President, President, Past-President - 1977-78-79
CANADIAN DENTAL ASSOCIATION
Chairman, Council on Auxiliary Services - 1969-71
Facilitator, Workshop on Dental Auxiliaries - 1971
Member of the Board of Governors - 1978 to present
Member of the Executive Council - 1983 to present
WESTERN CANADA DENTAL SOCIETY
President, Past-President - 1981-83
NORTHERN ALBERTA INSTITUTE OF TECHNOLOGY and
SOUTHERN ALBERTA INSTITUTE OF TECHNOLOGY
Member, Dental Assisting Advisory Committees - 1970-80

ORGANIZATIONS: ALBERTA DENTAL ASSOCIATION
CANADIAN DENTAL ASSOCIATION
PIERRE FAUCHARD ACADEMY - 1953
INTERNATIONAL COLLEGE OF DENTISTS, Fellow - 1978
A.D.A.-C.D.A. LIAISON TO 1988 CALGARY WINTER OLYMPICS

OTHER: CANADIAN T.B. & RESPIRATORY DISEASE ASSOCIATION
Past-President, Alberta Chapter - 1962-63
Past-Vice-President, Canadian Chapter - 1964-65
CALGARY EXHIBITION & STAMPEDE
Associate Director - 1966 to present
ALBERTA MOTOR ASSOCIATION
Chairman, Calgary Branch - 1985-87
Vice-Chairman, A.M.A. Travel Agency - 1985-87
KINSMEN CLUB
K40 CLUB
ROTARY CLUB

BIOGRAPHICAL INFORMATION

NAME: Dr. Bryun SIGFSTEAD

ADDRESS: 304, 10454 - 82 Avenue
Edmonton, Alberta
T6E 4Z7

DATE AND PLACE OF BIRTH:
August 3th, 1944 - Rose Valley, Saskatchewan

POSITION/PRACTISE:
Private Practice - Orthodontics

EDUCATION:
University of Alberta - 1967 - D.D.S.
University of Alberta - 1973 - Cert. Orthodontics

DEGREES:
D.D.S.
Cert. Orthodontics

EXPERIENCE:
1967 - 1968 - General Practice - Saskatoon
1968 - 1971 - General Practice - Edmonton
1968 - 1971 - Part-time Instructor, U. of A.
1973 - 1975 - Part-time Instructor, U. of A.
1973 - 1987 - Orthodontic Practice - Edmonton

ORGANIZATIONS:
Edmonton & District Dental Society
President - 1977-78
Alberta Dental Association
President - 1984-85
Canadian Dental Association

OTHER:

AWARDS:

BIOGRAPHICAL INFORMATION

NAME: Leslie Stephen Allen

ADDRESS: 606 Ellice Ave Wpg. Man
R3G OA3

DATE AND PLACE OF BIRTH: Aug. 30 - 1942 Winnipeg

POSITION/PRACTISE: Private Practice

EDUCATION: Gorden Bell High School
Winnipeg, University of
Manitoba

DEGREES: B.Comm - 1965
DMD - 1969

EXPERIENCE: Private Practice - 1969-
Present
President Winnipeg Dental
Society 1981-82
Pres. Manitoba Dental Assoc
1985 Board Member Man.
Dental Assoc. 1982-86
Chairman-Subcomittie, Third
Party

ORGANIZATIONS: CDA-Alternative Delivery
Systems 1986-87
Manitoba Dental Assoc.
Canadian Dental Assoc.
ALPHA OMEGA F.I.C.D.

OTHER: Part-Time Instructor
University, Manitoba
1969-1979

AWARDS:

GILLES DUBE
125 BOUL. PROVIDENCE
LACHUTE (QUEBEC)
J8H 3L4
514-562-8531

DATE DE NAISSANCE: AOUT 04 1954
ETAT CIVIL: MARIE
ENFANTS: GENEVIEVE 9 ANS
MARIE-HELENE 7 ANS

ETUDES PRE-UNIVERSITAIRE

D.E.C. en Sciences de la Santé au cégep Edouard-Montpetit 1970-72

ETUDES UNIVERSITAIRES

D.M.D. à l'Université de Montréal 1973-1977

Année terminale d'une maîtrise en Administration des Services de
Santé à la faculté de Médecine de l'Université de Montréal. (1982)

EXPERIENCE PROFESSIONNELLE

Pratique privée 1977...

ASSOCIATIONS

Représentant étudiant de l'Université de Montréal au congrès de
l'A.D.C. en 1974.

Administrateur de la région des Laurentides de l'A.C.D.Q. (1980...)

ASSOCIATIONS (Suite)

Membre de l'exécutif de l'A.C.D.Q. 1982-1986

Membre et directeur de différents comités de l'A.C.D.Q. (1980...)

Président Société Dentaire des Laurentides (1980-1981)

Gouverneur de l'A.D.C. (1986...)

Membre de l'exécutif de l'A.D.C. (1986...)

BIOGRAPHICAL INFORMATION

NAME: Michael J. Crompton

ADDRESS: 567 St-George Street
Moncton, New Brunswick
E1E 2B9

POSITION/PRACTISE: Orthodontist in Moncton since 1961

EDUCATION: Graduated 1957 - McGill University
in Dentistry

Attended University of Montreal
1959-1961

DEGREES: Diploma in Orthodontics - 1961

ORGANIZATIONS: Past President - Canadian Dental Association
1976
Past President - N.B. Dental Society
Past President - Canadian Association of
Orthodontists

Currently President - Royal College of
Dentists of Canada
Member of Moncton City Council - 1970-1974
Past President - Moncton Rotary Club 1970

Fellowship - Royal College of Dentists of
Canada 1967
Fellowship - International College of Dentists
1978
Fellowship - American College of Dentists
1985

.../2

OTHER:

Past President - Moncton Boys Club 1964-1966
Currently Chairman - Advisory Board - Moncton Boys and Girls Club
Currently Chairman - National Council Boys and Girls Clubs of Canada
Involved in fund raising for boys and girls clubs of New Brunswick for past three years.

Vice-Chairman - Skate Canada 1977 Moncton
Executive Committee - Canadian Figure Skating Championships - Moncton 1974

Executive Committee - New Brunswick Hawks
Calder Cup Champions - 1981-1982

Served on Vestry - St. James Anglican Church

During time at University, served on Supervisory Staff of Boys Home of Montreal for six years.
Mr. Vernon MacAdam was Executive Director of the Boys Home as well as National Director of Boy's Clubs of Canada at that time.

BIOGRAPHICAL INFORMATION

NAME: Dr. Robert R. Schiewe

ADDRESS: 536 River Street, Thunder Bay, Ontario
P7H 3S2

DATE AND PLACE OF BIRTH: September 16, 1939, Fortwilliam, Ont.

POSITION/PRACTISE: Private Practice General Dentistry
in Thunder Bay, Ontario

EDUCATION: Faculty of Dentistry, University of
Toronto

DEGREES: D.D.S. BSc. Dentistry (Anesthesiology)

EXPERIENCE: Graduated University of Toronto in 1963
Teaching Fellowship University of
Manitoba 1963-1964
1964-1966 Private Practice
1966-1967 Graduate School University
of Toronto
1967 to present Private Practice
in Thunder Bay

ORGANIZATIONS: Member Thunder Bay Dental Association
Member Ontario Dental Association
Member Canadian Dental Association
Past-President of the ODA
Past-President of TBDA
Past Board Member of CDA
Presently Member of Board of CDSPI

OTHER:

AWARDS: ODA Award of Merit
ODA Past-President

BIOGRAPHICAL INFORMATION

NAME: GRAHAM, BRUCE S.

ADDRESS: FACULTY OF DENTISTRY, DALHOUSIE UNIVERSITY
HALIFAX, N.S. B3H 3J5

DATE AND PLACE OF BIRTH: SEPTEMBER 26, 1947 WINDSOR, ONTARIO

POSITION/PRACTISE: ASSISTANT DEAN (ACADEMIC AFFAIRS)
PROSTHODONTIST

EDUCATION: D.D.S. UNIVERSITY OF TORONTO 1970
M.S. (PROSTHODONTICS) OHIO STATE UNIVERSITY 1974
M.R.C.D. (c)

DEGREES:

EXPERIENCE: PROSTHODONTIC PRIVATE PRACTICE 1 day/week 1974
DENTAL EDUCATOR 1974
HEAD, DIVISION OF REMOVABLE PROSTHODONTICS 1980-85
FACULTY OF DENTISTRY
DALHOUSIE UNIVERSITY
ASSISTANT DEAN 1985 -

ORGANIZATIONS:

IADR
AADS
CADR
ACFD-DELEGATE
APC - ASSOCIATION OF PROSTHODONTISTS OF CANADA

OTHER:

AWARDS:

BIOGRAPHICAL INFORMATION

NAME: Dr. John G. Thompson

ADDRESS: 79 Neck Road, Rothesay, New Brunswick, E2G 1K4

DATE AND PLACE OF BIRTH: December 29, 1938, New Glasgow, Nova Scotia

POSITION/PRACTISE: Private Practice
Rothesay, New Brunswick, May, 1969 - April, 1978
Quispamsis, New Brunswick, May, 1978 - to present

Dentistry on Handicapped Children
- Dr. William F. Roberts, Teaching Hospital, West
Saint John, Comprehensive treatment under local
and general anesthetic Sept. 1974 to present

EDUCATION: Graduate Colchester County Academy, Truro, Nova Scotia,
1956
Undergraduate: Mount Allison University, Sackville, New
Brunswick, 1956 - 1960

DEGREES: D.D.S. Dalhousie University, 1965

EXPERIENCE: Military: Served Royal Canadian Dental Corps, 1965 -
1968 with 6 months posting in Cyprus.

ORGANIZATIONS: President, Saint John Dental Society - 1973
Saint John Representative on the New Brunswick Dental
Society - 1969 - 1971
1974 - 1978
Legal Committee, New Brunswick Dental Society
- 1969 - 1971
Caribbean Program - volunteer in St. Lucia, 6 weeks, '75
Continuing Education Chairman, New Brunswick Dental
Society - 1975 - 1976
Member of Committee on Auxiliaries, 1976 - 1977
Executive Director Registrar, New Brunswick Dental
Society, 1978 to present
CDA Conference on Priorities, 1981
CDA Ad Hoc Committee on Licensing Authorities, 1982
Chairman, Secretary's Conference - January, 1982
President, District 19 Strings, parents group, 1982
to present
Director, Nova Scotia String Music Camp, 1984

OTHER: Married to Lois Helen (Cannell) of Halifax
3 sons: Matthew 17, Daniel 14, Timothy 10
Coach - mini basketball, 1978 - 1981
Hobbies - Stained Glass, hiking, singing

AWARDS:

BIOGRAPHICAL SYNOPSIS

JACQUELINE P. ROBARTS

Jacqueline P. Robarts, the only woman President of a College of Applied Arts and Technology in Ontario, assumed the Presidency of Niagara College, responsible for serving the entire Region of the Municipality of Niagara, in June, 1978. Prior to being named President of Niagara College, Miss Robarts was Vice-President (Academic) of Humber College of Applied Arts and Technology of Metro Toronto. Before her Vice-Presidential appointment in 1977 Miss Robarts served as Principal of Humber's North, Osler and Quo Vadis Campuses from 1974.

A native of Windsor, Miss Robarts is a registered nurse having graduated from the Civic Hospitals School of Nursing in Hamilton, Ontario. She also holds a Bachelor of Science in Nursing degree from the School of Nursing at the University of Toronto and is a candidate for a Master of Education degree in adult education from the Ontario Institute for Studies in Education.

A dedicated educator, Miss Robarts has pledged to improve the quality of all educational services offered by Niagara College to its large and diverse student population.

As a consequence of Miss Robarts' presidency, Niagara College has gradually shifted from an applied arts orientation to one responsive to the heavy metal manufacturing and machining as well as marine needs of the region's businesses and industries, sectors particularly critical to the future of the Province of Ontario.

Miss Robarts has been involved in the various activities of the Committee of Presidents since 1978, served as Chairman from 83-07-01 to 84-07-01 at which time she assumed the position of Past-Chairman. She has been a Commissioner on the Ontario Manpower Commission since 1982.

It is Miss Robarts' goal to work toward the fulfillment of the many needs of our region by helping to provide our future generation with leaders well equipped to cope with the challenges of tomorrow.

1985-01-16

BIOGRAPHICAL INFORMATION

NAME: James Hamilton Prentice Main

ADDRESS: Faculty of Dentistry, University of Toronto, 124 Edward St.,
Toronto, Ont. M5G 1G6

DATE AND PLACE OF BIRTH: 7th June, 1933, at Biggar, Scotland

POSITION/PRACTISE: Professor and Head, Dept. of Oral Pathology, University of
Toronto;
Head, Dept. of Dentistry, Sunnybrook Medical Centre.

EDUCATION: University of Edinburgh
Northwestern University, Chicago

DEGREES: B.D.S., University of Edinburgh, 1955
Ph.D., University of Edinburgh, 1964
F.D.S.R.C.S.E. (Fellow in Dental Surgery, Royal College of Surgeons of
Edinburgh)
F.R.C.Path. (Fellow of the Royal College of Pathologists)
F.R.C.D.(C) (Fellow of the Royal Collge of Dentists of Canada)

EXPERIENCE:

Flight Lieutenant, Royal Air Force, 1957-60.
Carnegie Research Fellow, University of Edinburgh, 1960-61.
Senior Lecturer in Oral Pathology, University of Edinburgh, 1961-69.
International Research Fellow, National Institutes of Health, Bethesda, Md., U.S.A.,
1964-65.
Professor of Oral Pathology, University of Toronto, 1969-present.

ORGANIZATIONS:

Canadian Dental Association
Ontario Dental Association
Canadian Academy of Oral Pathology
American Academy of Oral Pathology
International Association of Oral Patholgoists
International Association for Dental Research

OTHER:

President-Elect, International Association for Dental Research

AWARDS:

Clark Prize for Cancer Research, 1968.
Colgate Palmolive Prize for Dental Research, 1966.

BIOGRAPHICAL INFORMATION

NAME: Dr. Blake A. Creaser

ADDRESS: P.O. Box 130
New Germany
Lunenburg County, N.S. BOR IEO

DATE AND PLACE OF BIRTH: June 22, 1951
Bridgewater, Nova Scotia

POSITION/PRACTISE: Private Practice: General Dentistry

EDUCATION: West Kings High School
Dalhousie University

DEGREES: D.D.S. (Dalhousie University) 1976

EXPERIENCE: General Practice: 1976 - 1987 (New Germany)
Consulting Staff: South Shore Regional Hospital
Past Secretary/Trea.: South Shore Dental Society
Past. Pres.: Family & Children's Services of
Lunenburg County
Past Chairman & present member: Nova Scotia
Dental Association - Professional Development
Committee.

ORGANIZATIONS: Member: Nova Scotia Dental Association
Canadian Dental Association
International Association of Orthodontics
Phi Kappa Pi

OTHER:

AWARDS: Silver D Award - Continuing Ed. in Dentistry
Dalhousie University.

BIOGRAPHICAL INFORMATION

NAME: Dr. Jean Sirois

ADDRESS: 920 Blvd. St-Joseph
Hull (Québec) J8Z 1S9

DATE AND PLACE OF BIRTH: September 14, 1952, Montreal

POSITION/PRACTISE: General Practice

EDUCATION: D.M.D. University of Montreal - 1976

DEGREES: D.M.D.

EXPERIENCE:

ORGANIZATIONS: President, Hull Study Group
Administrator, ACDQ

OTHER:

AWARDS:

BIOGRAPHICAL INFORMATION

NAME:	John Hardie
ADDRESS:	12, Bayswater Place, Ottawa, Ontario
DATE AND PLACE OF BIRTH:	June 28th, 1941
POSITION/PRACTISE:	Chief, Department of Dentistry Ottawa Civic Hospital
EDUCATION:	Ardrossan Academy 1953-58 Glasgow University 1958-63 University of Western Ontario 1975-78
DEGREES:	Bachelor of Dental Society 1963 Master of Science (Pathology) 1978 Fellow, Royal College of Dentists Canada
EXPERIENCE:	General Dental Practice 1963-74 Graduate Training 1975-1978 Faculty Appointment University of Alberta 1978-80
ORGANIZATIONS:	Ottawa Dental Society Ontario Dental Association Canadian Dental Association Canadian Academy of Oral Pathology American Academy of Oral Pathology
OTHER:	Pierre Fauchard Academy
AWARDS:	CDA Research Foundation Award 1979 Canadian Microscopic Society Award 1978 Medical Research Council Award 1979

BIOGRAPHICAL INFORMATION

NAME: William Karl Hettenhausen Dentist

ADDRESS: Y.T.F.L. Foundation, P.O. Box 2631,
THUNDER BAY, Ontario, P7B 5G2 (807) 622-2600

DATE & PLACE OF BIRTH: 07/07/48 Thunder Bay (Port Arthur)

POSITION/PRACTISE: Executive Director: Y.T.F.L. Foundation
Private Practice: Limited to Diagnosis,
Consultation, Primary Prevention, Nutrition &
Diet Analysis, by referral only.

EDUCATION: Port Arthur Collegiate Institute
York University (1 year Honour Science)
University of Toronto

DEGREES: D.D.S. (University of Toronto, 1972)

EXPERIENCE: General Practice, 1972-1976 Thunder Bay
Limited Practice - Primary Prevention &
Nutrition, 1976-1987
Executive Director - Your Teeth for a
Lifetime Foundation, 1978-1987
Thunder Bay Dental Assn. Dental Health
Week Committee, 1973-1987
O.D.A. Nutrition Sub-Committee for Health
Care, 1983-84
O.D.A. Communications and Public Education
Committee, 1984-(1990)
Membership Chairman, Ontario Society for
Preventive Dentistry Board 1985-(1989)
C.D.A. Book Reviews "Primary Preventive
Dentistry" & "Oral Self Care Strategies
for Preventive Dentistry" Sept./Nov.1986

ORGANIZATIONS: Y.T.F.L. Foundation Patron Membership #0033
Thunder Bay Dental Assoc.(Honorary Membership)
Ontario Dental Association
Canadian Dental Association
Canadian Health Education Specialists' Society

OTHER: 1979-1987 31 Continuing Education Lectures for
Royal College of Dental Surgeons of Ontario
1982 C.D.A./O.D.A. Joint Convention clinic
on "Generating Health in the Oral Environment"
1983 5 Continuing Education Lectures for the
University of British Columbia (+1 in Sept.87)
1984 College of Dental Surgeons Saskatchewan

AWARDS: 1972 H. A. Hoskin Award (Highest in Diagnosis)
1972 Canadian Oral Prophylactic Gold Medal
1987 Ontario Dental Association Service Award
9 Certificates of Appreciation from CDA & ODA

BIOGRAPHICAL INFORMATION

NAME: Dr. Gregory Martin RITSON-BENNETT

ADDRESS: 6, 4903 - 53 Street
P.O. Box 265
INNISFAIL, Alberta TOM IAO

DATE AND PLACE OF BIRTH:

26 February 1946 - Plymouth, England

POSITION/PRACTISE:

Private Practice

EDUCATION: University of Alberta

DEGREES: D.D.S. - 1977
B.Sc.
P.D.A.D. (Ed)

EXPERIENCE:

Private Practice - Innisfail, Alberta - 1977 to present
Dental Health Promotion Committee, Chairman - 1985-87
Member - 1978-87
Auxiliary Services Committee, Member
Central Alberta Dental Society, President

ORGANIZATIONS:

Canadian Dental Association
Alberta Dental Association
Central Alberta Dental Society

OTHER:

Rotary Club, Past-President

AWARDS:

BIOGRAPHICAL INFORMATION

NAME: Dr. Paul C. O'Brien

ADDRESS: 12 Gleneyre Street
St-John's, Newfoundland
A1A 2M7

DATE AND PLACE OF BIRTH: 1945, Gravesend, England

POSITION/PRACTISE: Private Practice

EDUCATION: St Bows College (High School)
Memorial University 1966
Dalhousie 1970

DEGREES: BSC (Memorial) 1966
DDS (Dalhousie) 1970

EXPERIENCE: General Practice 1970-87
Janeway Hospital:
Chief Staff Dentistry Childrens Hospital
1980-82
Medical Advisory Committee 1980-82
Audit Committee 1980-82
Credentials Committee 1980-82

ORGANIZATIONS: Past-President Avalon Study Club 1978
Treasurer Newfoundland Dental Association
1973-77
Chairman (Member) Newfoundland Dental
Association - Mediations 1980-82
1st Vice-President, 2nd Vice-President,
President - Newfoundland Dental Association
1983-86
Chairman Government Relations Committee
(NDA) 1985, 1986
Tariff Committee (NDA) 1986-87

APPENDIX II

CDA PRESIDENT'S AWARD

<u>University</u>	<u>1986-1987 Recipient</u>
Alberta	D.A. Lister
B.C.	Thomas Andrew Martin
Manitoba	Robert Barr
Dalhousie	Jeffrey Michael Bonang
Laval	Claudette Dion
Western Ontario	Yvonne E. Kirschner
Toronto	Michele Carr
McGill	Norman Y. Clement
Montreal	David Faucher
Saskatchewan	Kenneth Robert Dick

CURRICULUM VITAEDR. W.R. THOMPSON

- Born:** Campbellford, Ontario 28 October 1923
- Graduate:** Toronto 1949 - D.D.S.
Toronto 1969 - Oral Surgery Certification
- Practice:** Military service in numerous locations in Canada and overseas as a general practitioner, oral surgery specialist, clinical instructor and dental administrator
- 1961 - Advanced Dentistry Training, Walter Reed Army Medical Centre
- 1961-65 - Instructor at Canadian Forces Dental Services School, Canadian Forces Base Borden
- 1973 - Fellow of International College of Dentists
- Honorary Dental Surgeon to the Queen
- 1975-80 - Chairman of the Defence Forces Dental Services Commission of the F.D.I.
- 1976-82 - Director General Dental Services, Canadian Forces
- Member Board of Governors, CDA
- 1978 - Order of St John awarded by St John's Ambulance
- 1979 - Fellow of Royal College of Dentists
- Pierre Fouchard Medal awarded by National Order of Dentists of France
- 1980 - Executive Council CDA
- Executive Liaison to Council on Education
- 1982-83 - President of the Canadian Dental Association
- 1983-85 - Executive Council of Fédération Dentaire Internationale
- 1985 - Colonel Commandant of Canadian Forces Dental Services

...2

Curriculum Vitae
Dr. W.R. Thompson
Page 2

Member: Canadian Dental Association
Ontario Dental Association
Royal College of Dental Surgeons of Ontario
Canadian and Ontario Societies of Oral and Maxillo
Facial Surgery

Personal: Married
Wife - Doris
Children - Barbara, Paul and Scott

Hobbies: jogging, boating, X country skiing, gardening



c.c. Dr. Crawford

Nova Scotia Dental Association

SUITE 604, 5991 SPRING GARDEN ROAD
HALIFAX, N.S. B3H 1Y6

TELEPHONE 902-420-0088

May 25, 1987

Dr. P. Ralph Crawford, Chairman
Council on Nominations, Awards & Trusts
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, ON
K1G 3Y6

Dear Dr. Crawford:

It is with great pleasure that I on behalf of the Nova Scotia Dental Association submit the name of Dr. James Douglas McLean in nomination for the C.D.A. Distinguished Service Award.

I will not detail Dr. McLean's contribution to the profession as his curriculum vitae enclosed chronicles his many years of service.

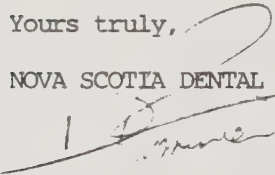
No C.V. can however import the qualitative contributions of an individual and such is the case with Dr. McLean. He for many years strongly influenced the careers of those he came in contact with providing wise counsel and determined leadership. He has served the profession, nationally and provincially and he has been an outstanding ambassador for the profession through his community service activities.

In 1985 he received the P.S. Christie Award for Distinguished Service, the N.S.D.A.'s highest award.

We appreciate Executive Council's consideration of our nomination.

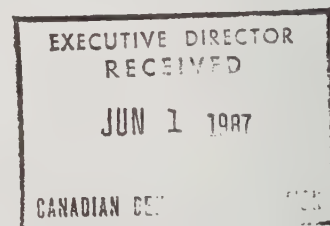
Yours truly,

NOVA SCOTIA DENTAL ASSOCIATION


D.V. Pamenter
Executive Director

DVP/ja

Enclosure



JAMES DOUGLAS MCLEAN

HOME ADDRESS: 54 Lake Drive
Bedford, Nova Scotia
B4A 1H9

Telephone: 835-3609

CITIZENSHIP: Canadian

DATE OF BIRTH: 12 February 1920

MARITAL STATUS: Married to Audrey Elizabeth Mitchell

CHILDREN:

Douglas Kenneth Bowman McLean
Donald Mitchell McLean
Margaret Ainslie (McLean) Moignard
Leslie Elizabeth McLean

EDUCATION:

Public and High School
Regina, Saskatchewan
Senior Matriculation
Central Collegiate, 1937

Regina College
University of Saskatchewan
1937 - 1938

University of Toronto
D.D.S.
1938 - 1942

University of Minnesota
Academic Year Post-Graduate Studies in Restorative Dentistry
1946 -

University of the Pacific
Restorative Dentistry
1976

Dominion Dental Council
Certificate
1942

HONORS AND AWARDS:

Fellowship, American College of Dentists
1959 -

Fellowship, International College of Dentists
1954 -

Fellowship, Royal College of Dentists (Canada)
Honorary
1975 -

Fellowship, Academy of Dentistry International
Honorary
1986 -

Dean Emeritus
Faculty of Dentistry, Dalhousie University
1985 -

ACADEMIC APPOINTMENTS:

Part-time Associate Professor
Faculty of Dentistry, University of Alberta
1947 - 1953

Dean
Faculty of Dentistry, Dalhousie University
1954 - 1975 (resigned)

Professor
Faculty of Dentistry, Dalhousie University
1953 - 1985

UNIVERSITY COMMITTEE APPOINTMENTS:

Member of Senate
Faculty of Dentistry
Dalhousie University
1953 - 1985

PROFESSIONAL EXPERIENCE:

a) Private Practice

Regina, Saskatchewan
January - April 1946

Edmonton, Alberta
1947 - 1953

Part-time
Halifax, Nova Scotia
1980 - 1986

b) Government

Captain
Canadian Dental Corps
1943 - 1946

PROFESSIONAL SOCIETIES:

Canadian Dental Association, 1942 -
Alberta Dental Association, 1947 - 1953
Nova Scotia Dental Association, 1953 -
Halifax County Dental Society, 1953 -

POSITIONS HELD IN PROFESSIONAL ORGANIZATIONS:

Chairman, Committee on Ethics
Canadian Dental Association
1949 - 1958

Chairman, Council on Dental Education
Canadian Dental Association
1958 - 1962

Member, Council on Dental Education
Canadian Dental Association
1975 - 1978

Chairman, Survey Policy Committee
Canadian Dental Association
1975 - 1978

Founding Chairman, Board of Trustees
Canadian Fund for Dental Education
Canadian Dental Association
1962 - 1970

Member, Task Force on Dental Care
Nova Scotia Council of Health (Provincial Government)
Canadian Dental Association
1971 - 1972

COMMUNITY ACTIVITIES:

- Past President, Neptune Theatre Foundation, Halifax, Nova Scotia
- Member and Past President, Halifax Branch of the Canadian Red Cross Society

COMMUNITY ACTIVITIES CONT.:

- Past President, Nova Scotia Division of the Canadian Red Cross Society
- Currently Hon. Vice President Nova Scotia Division, Canadian Red Cross Society
- Past President and Hon. Counsellor, Central Council of National Society, Canadian Red Cross Society
- Currently Past President, Nova Scotia District of the Canadian Bible Society
- Member and Former Clerk of Session, Fort Massey United Church, Halifax, Nova Scotia
- Former Member of the Board of Governors, Atlantic School of Theology
- Former Member of Board of Governors, and Chairman, Pine Hill Divinity Hall

COUNCIL ON STUDENT AFFAIRS

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

Council members: Mr. Bob Barr, Chairman, Univ. of Manitoba
Mr. Rick Odegaard, Univ. of British Columbia
Mr. Dave Chorkwa, Univ. of Alberta
Mr. Robin Slowenko, Univ. of Saskatchewan
Mr. Donald Chin, Univ. of Manitoba
Mr. Mohamed Gulamhussein, Univ. of Toronto
Miss Wendy Street, Univ. of Western Ontario
Miss Madeleine Shildkraut, McGill Univ.
Mr. François Chartrand, Univ. de Montréal
Mr. Jacques Brouillet, Univ. Laval
Mr. Doug Lovely, Dalhousie Univ.
Miss Pam Zakarow, Student Governor, U.W.O.
Dr. Sam Sgro, Past Student Governor, Montreal, Que.
Dr. Liliane LeSaux, Past Chairman, London, Ont.

Dr. Don MacFarlane, Executive Liaison, Vancouver, BC.

1. Council Meetings

Council has met once since reporting to the Interim Board, on March 14, 1987, at CDA Headquarters.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

2. Practice Management Manual

Revisions to the Manual are underway and it is hoped a review of the revised chapters will be carried out at the September 1987 Canadian Dental Students Conference.

Council's concern that not all schools utilize the Manual to the extent that it should be, has resulted in the decision to promote the Manual to students and faculty at functions such as the Welcome to the Profession receptions and grad events, when possible.

COUNCIL ON STUDENT AFFAIRS

3. Canadian Fund for Dental Education

CDA Student Reps are maintaining their promotion of the CFDE at the schools in various ways.

Representatives have addressed the Dental Student Societies, held school events with proceeds directed to the Fund, and requested the Deans to speak to the student bodies on CFDE activities.

4. Quebec and the NDEB Certificate

Council has been informed by CDA 's Accreditation Department of the efforts being made to change the status of the NDEB Certificate in the province of Québec. Council is hopeful this will occur and awaits further reports on this subject.

5. Student Membership

CDA student membership has been maintained at 96% of all undergraduate dental students.

There will be a fee increase of \$2.00 for 1987-88, to \$16.00.

6. Canadian Dental Students' Conference

As previously reported, the 1987 Conference will be held in Saskatoon from September 23-26.

Council, at its March meeting, made a decision to initiate a Conference theme. Topics such as stress for dental students, drug and alcohol abuse in the profession, dental manpower, provincial dental plans are being considered for this year's meeting. Council feels that this will provide a base for discussion of important areas in dentistry, at the Conference, and subsequent meetings.

7. Scheduling of Council on Student Affairs Meetings

Council supports the suggestion made by the CDA Roles and Responsibilities Committee to schedule its meetings to coincide with a major CDA activity, that the Students' Conference be held in conjunction with a CDA meeting, and that a second CSA meeting annually be approved if held immediately following the Students' Conference.

Council will attempt to schedule its meetings accordingly, when examination and academic schedules permit.

COUNCIL ON STUDENT AFFAIRS

8. CDA Grad Packs

The grad packs were again distributed to all graduating student members. Included in the package were copies of the CDA pamphlets, order form, CDA information brochure, the CDA Code of Ethics, information on the Standard Dental Claim form and Standard Dental Referral form, change of address form, and the June issue of the CDA Journal.

9. Student Involvement in Organized Dentistry

Council is appreciative of the opportunity to be involved, by representation at the following meetings:

National Dental Examining Board of Canada
American Student Dental
Association of Canadian Faculties of Dentistry
Council on Education and Accreditation
CDA Board of Governors

At its March 14th meeting, representatives discussed at length the areas of concern being expressed by students at their respective schools. Reps met with their student body following the Students' Conference in September, and reported back to Council that some of these concerns include stress for the dental student, prelicensure and the dental curriculum.

It was concluded that these concerns should be channelled back to the faculties via reports to the ACFD, the Council on Education and Accreditation, and through faculty-student liaison.

Attached is a position paper by Pamela Zakarow, CSA representative to the Council on Education and Accreditation.

APP.1

Summary

The Council on Student Affairs appreciates the opportunity of being involved in the important issues being addressed by the CDA, and for the support the Association generously gives dental students.

Respectfully submitted,

Bob Barr, Chairman
Council on Student Affairs

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Student Affairs with appreciation.

POSITION PAPER BY THE COUNCIL ON STUDENT AFFAIRS

TO THE COUNCIL ON EDUCATION & ACCREDITATION

JUNE 1-4, 1987

In recent years, the members of the Council on Student Affairs have become cognizant of the fact that various councils and committees of the Canadian Dental Association are receptive to our input as a body representing dental practitioners of tomorrow. We, the members of CSA, are very honoured to be a part of the decision-making process that guides the direction of our profession. In lieu of the fact that we are granted the privilege of voting on the Council on Education and Accreditation, and have a vested interest in shaping the curriculum taught at the various dental schools in Canada, Council would like to formally express our view on a number of issues we find key to our existence. Three paramount issues at the CSA level are the issues of prelicensure, proposed changes to the curriculum, and stress as it relates to dental school.

A. Prelicensure

In reports to our Council by the various CSA representatives at the most recent meeting of CSA on March 14, 1987 in Ottawa, opposition was expressed by the vast majority of schools to the institution of a prelicense year into the current school curriculum.

Representatives from nine out of ten dental schools voiced strong opposition to the implementation of a prelicense year for the following reasons:

- (1) Dental school is long enough and could not warrant an additional year;
- (2) Students could not financially afford an extra year due to accumulating debts;
- (3) The structure of the prelicensure year is still not well understood by students and they are quite sceptical as to it's structure;
- (4) Is this year to have some sort of financial remuneration associated with it (i.e., are students to be "paid" for their services, as a medical intern is)?

UBC students wished to reserve judgement at this time on the proposed prelicense year until further information is provided on the nature of the program. Dr. Lilian LeSaux and I attempted to provide whatever information we had obtained on this matter to clear what appeared to be a somewhat confused issue. Though discussed at previous meetings, most current members of CSA were quite confused as to the concept of prelicensure. We did explain that, though the structure of the program was yet to be outlined, the prelicensure year did not necessarily dictate the addition of one extra year onto each dental program offered at Canadian dental schools. Rather, it involved the restructuring of the present dental school curriculum, to somewhat shorten the academic aspect of the program, thus freeing up more time for some additional clinical studies with the possibility of offering students a choice as to what area they wish to concentrate on during this period.

The intention of prelicensure is to expose students to a more clinically diverse spectrum of experience prior to engaging in private practice. In response to these remarks, the student representatives were receptive to any information provided by the Council on Education and Accreditation to this proposed program as soon as such information is available and would be pleased to discuss this topic again, once more concrete outlines were provided. The Council eagerly awaits further communication with your Council.

B. Changes to the Curriculum

With respect to future changes in dental school curriculum, all representatives voiced the opinion that dental schools need revision in this area. Most reps supported changes to the curriculum to allow more clinical time. Dalhousie and Toronto representatives stated that curriculum changes were presently underway which have lead to a somewhat disruptive year. Saskatchewan was hesitant about changing the curriculum, since they feel that the basic science program may be compromised. However, it was generally felt by all school representatives that there was some redundancy between information gained in basic science courses taken in the pre-dental years and those provided in the first two years of dental school. A majority were in favour of making more course prerequisites for dental school, and therefore easing up the academic load of dental school. It was hoped that by restructuring the curriculum, more time would be gained to devote to clinical "wetfinger" dentistry in the second year or even the first year of the program. The Council members are very eager to take an active part in such a revitalization of the program at their respective schools, and would encourage the opportunity to be included in the decision-making process.

C. Stress

A burning issue with members of CSA is the inherent problem of stress and its management at the dental school level. As a result of the stress surveys conducted in the fall of 1985 and discussed at the ACFD conference in June 1986, most schools were surprised to see that stress was an even greater concern/problem at their school than anticipated. Though there were concerns about the design of the stress survey itself, most schools were in favour of having this parameter monitored and assessed, and it is hoped that the survey will repeat itself in the near future to see if levels have diminished. The stress survey outlined specific areas in dental school that are particularly stressful to students, i.e., deadlines, patient cancellations, exams, unresponsive or irreproachable instructors, etc. The Council hopes that these areas will be highlighted to each dental school dean with the hope that measures will be taken to alleviate the stress generated from these problem areas. Once again, members of council voiced their interest in collaborating with the deans of dental schools to help alleviate this problem in the future.

I have elaborated on three issues in which the CSA is interested and would like to change for the betterment of all Canadian dental students. The CSA is expanding its scope of activity and is hoping to become a driving force in implementing change, rather than being a mere receptacle through which a vast amount of important information is filtered. We are there to assist organized dentistry and encourage any council or committee to ask for our help or expertise in any area which may improve dental education in this country.

Respectfully submitted,

Pamela J. Zakarow,
CDA Student Governor,
Council on Student Affairs.

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY
L'ASSOCIATION DES FACULTES DENTAIRES DU CANADA

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

The Association celebrated its 20th Anniversary at the recent House of Delegates meeting held in June in Vancouver. Twenty years later, in 1986-87, our concerns and goals really haven't changed. Concerns may have focused as they must do on certain issues at particular times but the overall philosophies and goals of our Association remain the same.

I am pleased that the House of Delegates ratified the decision to move our headquarters to the Canadian Dental Association in Ottawa. We expect that this opportunity will provide a greater national profile and a chance to liaise with CDA, as well as other nationally based organizations, to our mutual benefit. We look forward to the relocation and are extremely fortunate that Mrs. Stella Taylor, our Executive Assistant, and her family are prepared to undertake a move to Ottawa with the Association.

The House of Delegates also passed a motion with respect to representation of the CDA at the ACFD/AFDC Executive level. We are requesting that the Chairman of the Council on Education and Accreditation as well as the CDA's Executive Liaison to that Council, share the responsibility of membership on the ACFD/AFDC Executive. To date, the role has been ably fulfilled by the Chairman of Council. However, we feel that this will provide a greater level of understanding between the two Executive bodies that could lead to future cooperative endeavours.

I am pleased to report that over the course of the year we have welcomed new Affiliate members to the organization which now swells our ranks to a total of fifteen. These represent Auxiliary Education programs both in dental hygiene and in dental assisting and the Section on Dental Auxiliary Educators provides them with an opportunity at the national level for exchange and discussion.

I am pleased to report that again the Summer Teaching Institute was a great success. In addition, this summer activity was expanded to include a Management Institute to assist faculty members in becoming more proficient in the administration of the academic program. Interest has grown and attendance was increased this year in an effort to accommodate more participants. We are very pleased with the participation and response to the Institute and are always grateful for the support that is generously given by the Canadian Fund for Dental Education in addition to faculty support.

A new committee has been constituted within ACFD/AFDC. It will consist of the Deans of the dental schools and the President of ACFD/AFDC. There continues to be areas of ongoing interest and concern where a meeting of the Deans and President would be most appropriate and ACFD/AFDC can provide that forum and recognition.

The House of Delegates confirmed that there are two fundamental activities which they deem critical to the future of our profession. They involve:

- 1) The development of a standardized protocol for data collection which will provide a more scientific rationale for making future decisions related to dental manpower and dental education; and,
- 2) A strategic plan for the future of the dental profession in Canada. To that end, we are looking forward to the CDA Teaching Conference which will address these matters.

Also, over the course of the year, the Association prepared guidelines for assessment and retraining programs for dentists. These guidelines were presented and accepted by the House of Delegates and a motion was passed that encouraged Member Institutions to participate in the assessment and retraining of dentists wherever possible.

In this year of growth and challenge to us all, I look forward to a stronger and better integrated relationship between our two Associations.

Respectfully submitted,

Marcia A. Boyd
President

ADOPTION OF REPORT

The Board of Governors receives the report of the Association of Canadian Faculties of Dentistry for information.

CANADIAN FUND FOR DENTAL EDUCATION

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

1. Meetings

Since reporting to your Board's 1987 Interim Meeting, CFDE has held its Annual Board of Trustees Meeting, which took place in Ottawa on April 26-27, 1987. I am pleased to have this opportunity to report on the Trustees' deliberations and CFDE's activities since my last report.

ITEMS REQUIRING BOARD ACTION

2. Change of Name

The Board spent a great deal of time at its meeting discussing the future directions of CFDE. The relatively small percentage of dentists contributing to CFDE is of continuing concern to the Trustees. In addition, income from business and industry has decreased over the past three years. As 1987 is CFDE's 25th Anniversary, it was felt that this would be a good time to change the thrust of the organization. The Trustees are, therefore, taking significant steps to increase the Fund's profile and broaden its scope to include additional emphasis on public awareness programs and other projects which are not specifically related to the education of dentists. In order to better reflect this new direction, the Board proposed a change of name for the Fund to the "Canadian Fund for Dental Health" and, in French, "Fonds canadien pour la santé dentaire". A new logo has also been approved.

I would request that the following motion be considered by the CDA Executive Council and, if deemed appropriate, permission to use the new name be granted immediately, pending legal approval.

RESOLVED:

87.140 THAT the name of the Canadian Fund for Dental Education (Fonds canadien pour l'enseignement dentaire) be changed to the Canadian Fund for Dental Health (Fonds canadien pour la santé dentaire), effective immediately.

DEFEATED

NOTE: This motion was defeated pending further investigation on the roles of the CDF.

CANADIAN FUND FOR DENTAL EDUCATION

3. Appointment to the Board of Trustees

The Board of Trustees has profited from the expert counsel of one of its industry representatives, Mr. Fred Heaps of Dentsply Canada, over the past several years. Unfortunately, Mr. Heaps completes his term of office in October. CDA's approval of a replacement is sought.

RESOLVED:

- 87.141 THAT Mr. Lee Maddison of Citicorp Leasing be appointed to the CFDE Board of Trustees.**

ADOPTED

4. Murray McDonald Memorial Lecture

The CFDE Trustees wish to revise the guidelines for the Murray McDonald Memorial Lecture, which was established in 1985 to commemorate CFDE's former Executive Director. As the experience of Dr. William May, the first memorial lecturer, was not deemed to have been as successful as had been hoped, the Trustees felt a change in format was warranted. In future, if CDA is in agreement, the lecture will be held at the CDA convention, preferably at a breakfast or luncheon. The speaker will be of high profile and will speak on a non-scientific topic of general interest. The CFDE Board of Trustees will allocate a maximum of \$4,500 per year to the lecture (to be approved annually).

RESOLVED:

- 87.142 THAT the Murray McDonald Memorial Lecture be included in the CDA Convention program on an annual basis;**

THAT the lecture be on a non-scientific topic of general interest; and

THAT CFDE be given the authority to choose a lecturer and, in conjunction with the Convention Committee, choose a time and location which will ensure high profile of the presentation.

ADOPTED

5. Canadian Dental Foundation

The Board of Trustees spent a great deal of time at its meeting discussing the establishment of the Canadian Dental Foundation. We are concerned that the CDF and the CFDE will be competing in the same market. Although CFDE has been assured that this will not be the case, we would appreciate the opportunity to meet with representatives of the CDA (CDF) to discuss the purposes of both organizations and their methods of solicitation.

CANADIAN FUND FOR DENTAL EDUCATION

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

6. Board Structure

At its meeting, the Board of Trustees adopted a new structure, to include a Chairman-Elect. Dr. Ted Ramage, of Vancouver, has agreed to serve in this position. He will sit on the Management Committee, along with Mr. Robert Cajolet, Vice-Chairman, Dr. Louis Bernier, and myself.

7. Plans for 1987

As the Fund's accomplishments in 1986 are detailed in the annual report which was published in the April issue of the Journal of the Canadian Dental Association, I will focus on the decisions made by the Trustees at their annual meeting for the benefit of dentistry in 1987 and beyond.

In an attempt to increase the Fund's profile and earn more support for CFDE, the Trustees approved the second CFDE Lottery. The prize for 1988 will be an all expenses paid trip to the FDI annual meeting in Australia.

A total of \$182,100 was approved by CFDE's Board in aid of dental education, research and awareness in 1987. The major programs selected for support are as follows:

- (a) A total of \$18,000 has been allocated in 1987 for programs to increase public demand for dental health care. In addition to a previously approved awareness program for seniors, which will run over the course of 1987, the Trustees gave approval in principle to a grant of up to \$10,000 to CDA for a project within its Dental Awareness Program. A project proposal will be presented to the Management Committee for approval in November.
- (b) In addition, CFDE has combined the 1987 and 1988 grants for Dental Health Month in order to increase its profile during the campaign. It is hoped that the \$8,000 will be used for sole sponsorship of the DHM poster.
- (c) The third STI, entitled the CFDE/ACFD Summer Teaching and Management Institute, takes place this June. CFDE has, in light of the impressive results of the STI, seen fit to increase its grant to \$35,000 for 1987. The Fund has also approved a grant of \$30,000 for the 1988 Institute.

CANADIAN FUND FOR DENTAL EDUCATION

- (d) A grant of \$5,000 has been approved as seed money for Dr. Arto Demirjian, of the Université de Montréal, in his work to develop a subject-integrated videodisc for dental education. It is felt that this innovation will greatly advance dental education in the future.
- (e) Once again this year, CFDE is providing unrestricted grants of \$1,500, upon application, to each of the ten dental schools.
- (f) CFDE will continue its direct support for undergraduate students with a grant of \$1,000 per dental school. These grants are to be used for scholarships, awards, or prizes to two dental students per faculty and that CFDE be given appropriate recognition in the awarding of these funds.
- (g) The Student Clinician Program and Students' Conference will be supported again with grants of \$8,500 and \$7,500 respectively.
- (h) A total of \$35,500 was allocated for teacher/researcher training fellowships. Ten dentists were selected for assistance. There were no applications from hygienists this year.
- (i) The 1987 Teaching Conference on "Planning the Future of Dentistry and Dental Education" will receive CFDE funding of \$10,000. The grant was increased from \$7,500 in 1986 due to the importance of and wide appeal of this year's topic.
- (j) The Trustees will provide \$2,000 for educational projects run by the Ontario Dental Hygienists' Association. This grant is underwritten by a corporate sponsor. As the Canadian Dental Hygienists' Association is not holding a major convention or conference this year, overall grants to dental hygiene are down.
- (k) The income from the Lorne E. MacLachlan Endowment Fund of approximately \$9,000 will again this year be divided equally among the dental faculties at Toronto, Western Ontario, McGill and Dalhousie to benefit the prosthodontics departments, in accordance with the terms governing the endowment.

8. Appreciation

It has been a privilege to present this report to you on behalf of CFDE. In summary, I can only add that, in order to maintain our assistance to

CANADIAN FUND FOR DENTAL EDUCATION

- 5 -

dentistry, CFDE truly needs both your moral and financial support. To all those who gave to CFDE in 1986, I extend my thanks. I hope that CFDE can look forward to your continued support in 1987, the year of the Fund's 25th Anniversary.

Respectfully submitted,

J. Fred Reid. D.D.S., Chairman
CFDE Board of Trustees

ADOPTION OF REPORT

The Board of Governors receives the report of the Canadian Fund for Dental Education with appreciation.

THE ROYAL COLLEGE OF DENTISTS OF CANADA

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

Examinations

Applications for both Membership and Fellowship Examinations for May and June this year increased from a total of 23 at the same time in 1986 to 30, and number as follows:

	<u>Membership Exam.</u>	<u>Fellowship Exam.</u>
Dental Public Health	3	—
Endodontics	2	—
Oral and Max. Surgery	5	5
Oral Pathology	1	1
Orthodontics	6	—
Periodontics	4	—
Prosthodontics	3	—
	<u>24</u>	<u>6</u>

Written examinations were held in Portland (Oregon), Vancouver, Edmonton, Winnipeg, Detroit, London, Toronto, Quebec City and Halifax. Orals will be held in Vancouver, Winnipeg, Toronto and Montreal. Successful examinees will be admitted to the College at its Convocation to be held in Toronto on Saturday, September 19th, together with 6 new Fellows and 11 new Members from the December, 1986, examinations.

Vacancies on Council

The three-year terms of office of Councillors representing Oral Radiology, Orthodontics and Periodontics will be expiring this year, and those from Radiology and Orthodontics may be re-elected for a second term. The Periodontics section will have to elect a new representative, as Dr. Alan Winnick may not stand for a third term. Fellows and Members in all three specialties have been asked for nominations, and any necessary election will be held in July.

New Register

An up-to-date Register of Fellows and Members has recently been printed, and will be widely distributed with the June issue of the College's "Bulletin". Additional copies are available upon request at the College office.

Respectfully submitted,

Michael J. Crompton
President

ADOPTION OF REPORT

The Board of Governors receives the report of the Royal College of Dentists of Canada for information.

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

I am very pleased to have the opportunity to provide a report to CDA on the activities of the Canadian Dental Hygienists' Association.

In September, 1986, the CDHA endorsed the Executive Summary and Recommendations from the Report of the Working Group on the Practice of Dental Hygiene. The "Report" outlined recommendations with regard to Human Resources, Education and Regulation which CDHA is committed to pursue. Work has begun in response to some of the recommendations. The feasibility of others remains under investigation.

1. Human Resources:

- The Federal Working Group recommended that periodic surveys be conducted to maintain a current data bank on dental hygiene.

CDHA has committed fifty thousand dollars to a National Census Survey of Dental Hygienists which will provide current, detailed information on dental hygienists.

The Survey is being carried out by Patricia M. Johnson, R.D.H., B.Sc.D., M.Sc., Doctoral Candidate, University of Toronto and will:

- describe the dental hygiene workforce and workforce behaviour
- provide a data base upon which to carry out future studies
- enable Dental Hygiene to identify trends and project future practice patterns
- enable Dental Hygiene to evaluate the claims of others.

To our knowledge, this is the first census study of dental hygienists by dental hygienists that has been conducted anywhere in the world!

- The Federal Working Group also recommended that CDHA and Provincial Dental Hygiene organizations be directly involved in all activities relating to dental hygiene human resources.

CDHA has representation on the CDA Professional Resource Utilization Committee and is committed to a collaborative approach to the problem of potential future excesses in human resources.

2. Education

a) Accreditation:

Recommendations of the Federal Working Group and the CDHA National Certification Committee led to the following actions:

- CDHA has pledged full support of the role of CDA Council on Education and Accreditation in evaluation of Dental Hygiene Educational Programs and has further declared a commitment to work towards strengthening the accreditation process.
- CDHA has requested greater representation on the Sub-committee of "Council" which confers accreditation status on Dental Hygiene Programs.
- CDHA has requested "Council" to include one clinical expert on each survey team. This person could focus on, and evaluate the clinical aspects of the program by participating in chart audits and student evaluation processes over the duration of the site visit.
- CDHA has asked CDA to consider engaging a dental hygiene educator with expertise in higher education, to work with Mr. Brian Henderson, Director of Education and Accreditation in planning, organizing, providing consulting services, and conducting site visits.
- CDHA is working to achieve support in all provinces for the Competency Profile in Dental Hygiene that has been developed by a sub-committee of "Council".

b) Educational Programs:

- Two Year Diploma Programs:

CDHA is strongly in favour of a return to educational programs of at least two years in length. A return to a minimum of two years was recommended by the "Working Group".

This does not imply that the skills of dental assistants should be disregarded. In keeping with the principles of adult education, we advocate that dental assistants should be given credit for prior knowledge and skills, however, this should be done by assessing entry level skills in all areas of the curriculum.

- Post-Diploma Programs:

In accordance with the Federal Working Group recommendations, CDHA recognizes growing potential for post-diploma programs in Dental Hygiene and in that vein:

- CDHA requested that the entrance criteria for the DDPH (Diploma in Dental Public Health) be reviewed with a view to admitting dental hygienists.
- CDHA supports the establishment in Western Canada of a post-diploma program leading to a baccalaureate degree, in a university which has experience with a diploma program. The purpose of this education is to prepare hygienists for careers in research, education and community health.
- CDHA encourages the promotion of these roles to undergraduates, and the pursuit of research on the questions identified during the 1982 Conference on Dental Hygiene Research.
- CDHA acknowledges the possibility of a need for future reductions in the number of graduates, however, we advocate that programs reduce numbers rather than close, and that reductions should not be initiated until there is clear evidence of over-supply.
- CDHA would like to see better educational preparation of dental students with regard to the role, education, expertise of hygienists, and the practical aspects of employing them. We advocate the integration of dental and dental hygiene programs (especially in clinical areas) to encourage a collaborative approach to dental health care.
- CDHA actively promotes undergraduate and continuing education programs in the care of the elderly and other underserved groups.
- CDHA encourages the participation of all dental hygienists in continuing education through a variety of learning experiences.
- In response to a request from one of our members, CDHA is investigating how to assist with establishing a Dental Hygiene Program in the Dominican Republic. CIDA has indicated an interest in this project.
- We anticipate being asked for a position statement on privatization of dental hygiene education and are presently investigating the ramifications of proprietary schools (for example TRIDONT).

3. Regulations

CDHA believes that hygienists should assume a responsible role in the regulation of hygienists.

The Working Group Report recommended that regulations be vested in bodies composed primarily of hygienists, however, we realize this is impractical in several provinces. Nevertheless, we believe Dental Hygiene should seek significant voting representation on the provincial regulating bodies. Further, we advocate the periodic review of regulations governing dental hygiene practice with a view to enhancing dental health promotion.

CDHA advocates portability of dental hygiene credentials from province to province without examination, providing it can be determined that a candidate has graduated from an accredited school or his/her skills have been assessed against a national standard. If accredited graduates from all provinces were recognized by all provinces, supply and demand problems could be alleviated.

A National Certification Process, endorsed by provincial licensing authorities is a long-term goal of CDHA. In response to an indication from licensing authorities that a national examination was desirable - if it met provincial standards, CDHA investigated the establishment of a National Certification Process based on the NDEB model. The concept of National Certification as an alternate route to licensure has merit in that it provides a candidate from an unaccredited or foreign school, or a re-licensure candidate, with an opportunity for access to licensure of a portable nature. The option would also enhance the value of accredited status to schools and their graduates and render the accreditation process less susceptible to political pressures.

Still in the conceptual stage, it is our intent to develop the certification process with input from provincial authorities. If an exam is developed, a consultant with expertise in test and measurement will work with a Steering Committee to produce a mastery-based clinical and theoretical examination that reflects validated Clinical Practice Standards and the Competency Profile (both of these are in the final stages of development). Further investigations regarding authority and responsibility for the certification examination are underway.

CDHA has developed a Quality Assurance Model which will be reviewed at the 1987 session of the Board of Directors. In this model, released comprehensive examinations play a role in self-assessment.

CDHA would endorse regulatory changes to enhance expansion of the number of dental hygiene positions in community health settings which presently amount to only ten percent of the Canadian total.

4. Health Promotion

CDHA has developed an educational resource for the older adult. The resource, Smile for Life - A Dental Health Guide for the Older Adult was developed under the direction of Joanne Clovis, Chairman, CDHA Community Dental Health Committee with a \$95,000 grant from the Department of National Health and Welfare. Ten thousand copies have been distributed to dental hygienists, agencies and individuals on the mailing list of the National Advisory Council on Aging. Forty thousand free copies are available from the CDHA Central Office, and are in great demand!

CDHA appointee, Yvonne Knazan, Faculty of Dentistry, University of Manitoba, in cooperation with Dr. Colin Foster (appointed by the CDA Council on Hospital and Institutional Services) coordinated the development of a guide for people who provide care to chronic care patients. This document has not been published to date.

CDHA is represented on the Federal Group investigating the role of dental health professionals in health promotion.

CDHA has answered the Epp Report: Achieving Health for All - A Framework for Health Promotion. The CDHA document outlines the potential for health promotion by dental hygienists and will be published in the fall issue of the CDHA Journal.

5. Professional Activities:

Convention 1988 - Edmonton

The Annual Scientific Session will be held in Edmonton, August 21-24, in conjunction with the CDA Convention in Edmonton.

Chairperson
Josephine Julchli
9602 - 86 Street
Edmonton, Alberta

Convention 1989 - Ottawa

The Annual Scientific Session will be held in Ottawa when CDHA will host the International Symposium in Dental Hygiene.

Chairperson
Dale Scanlan
53 Ariel Court
Nepean, Ontario
K2H 8J1

Publication:

The Journal of the Canadian Dental Hygienists' Association, PROBE.

Editor
Fran Cotton, R.D.H., B.Sc.D., M.Ed.

The administrative structure, graphics, format and content of this publication have been reviewed and revised with a very favourable response. We appreciate and encourage collaboration with CDA.

Public Relations:

CDHA has appointed a Public Relations Officer, Audrey Newcombe (Immediate Past President).

CDHA has established liaison with ADHA for the purpose of sharing educational publications, programs and organizational expertise. The first meeting of the official committee will be held in Chicago in 1988.

Respectfully submitted,

Dianne Gallagher
President
CDHA

ADOPTION OF REPORT

The Board of Governors receives the report of the Canadian Dental Hygienists' Association for information.

CANADIAN SOCIETY OF PUBLIC HEALTH DENTISTS

REPORT TO THE 1987 ANNUAL CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

On 25 May 1987, the Canadian Society of Public Health Dentists (CSPHD) held its Annual Business Meeting at the Palais des Congrès in Montreal and a conjoint Scientific Session with the Association des Dentistes en Santé Communautaire du Québec (ADSCQ).

The major item for discussion was the almost complete depletion of the financial resources of the Society. This was attributed to a number of major factors: increased postage, printing and telephone costs, considerable increases in the costs of the Society's Journal, the fact there have been two (2) meetings in a nine (9) month period and unrealistically low annual dues.

The CSPHD has supported the movement from a newsletter to a Journal as a major benefit to its membership - however, directed the editor to investigate outright grants to the Journal and study the benefits of selling advertising.

The annual dues were raised to forty-five (\$45) dollars to be more in line with 1987 costs. A sub-committee under Dr. Roger Ellis' direction has been instructed to investigate benefits of having other than dentists members of the Society.

Since costs of travel of members seems to affect attendance, the decision was made to attempt to have meetings where large numbers of members reside - Central Canada. The next meeting will be held in Toronto in Spring 1988 and will be two (2) days in duration. Hopefully annual meetings can be held at the same time each year.

The afternoon Scientific Session was an excellent session arranged/chaired by Dr. Marcel Tenenbaum, a member of both Societies. Speakers and topics were:

- | | |
|-----------------|---|
| Dr. Amid Ismail | - "Epidemiology of Periodontal Disease: New Findings" |
| Dr. Paul Simard | - "Effectiveness of Fluoride Mouthrinsing in Quebec" |

.../2

-
- Dr. Roland-George LaFlèche - "Dental Needs of Elderly in Nursing Homes"
- Dr. Richard Lessard - "Water Fluoridation Strategy in Quebec"

Respectfully submitted,

Dr. Neil A. Farrell
Secretary-Treasurer

ADOPTION OF REPORT

The Board of Governors receives the report of the Canadian Society of Public Health Dentists for information.

CANADIAN ACADEMY OF ENDODONTICS

REPORT TO THE 1987 CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

The annual meeting of the Canadian Academy of Endodontics was held at Vancouver, B.C., September 26-29, 1986. The convention chairman was Dr. Fred Weinstein, assisted by Dr. Sharma Sinanan and Dr. John Diggins. Members and guests enjoyed an excellent scientific program as well as being able to visit EXPO '86.

The locations of future annual meetings were determined as follows:

- 1987 - Toronto (Westin Hotel) Oct. 29-Nov. 1/87
- 1988 - Edmonton, Alberta
- 1989 - Montreal, Quebec

The annual general meeting elected the following executive for 1986-87:

- | | |
|-----------------|--|
| Past-President | - Dr. Fred Weinstein, Vancouver, B.C. |
| President | - Dr. Herb Borsuk, Westmount, Quebec |
| President-Elect | - Dr. Wm. Christie, Winnipeg, Manitoba |
| Treasurer | - Dr. Lorne Chapnick, Toronto, Ontario |
| Exec-Secretary | - Dr. John Phillips, Oshawa, Ontario |

Respectfully submitted,

John M. Phillips,
Executive Secretary,
Canadian Academy of
Endodontics

ADOPTION OF REPORT

The Board of Governors receives the report of the Canadian Academy of Endodontics for information.

TRANSACTIONS
of the Canadian Dental Association

DÉLIBÉRATIONS
de l'Association dentaire canadienne